

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10256

10276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle -- Last ABEL		4. DATE OF DEATH Month October Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Jacob Abel		14. MOTHER'S MAIDEN NAME Rachael Cohen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 218-14-9276	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. VA Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 5, 1957 , to October 17, 1957 . I last saw the deceased alive on October 16, 1957 , and that death occurred at 7:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/17/57			
ACTUAL SIGNATURE Irving Freeman		M.D. VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-20-57	
22c. NAME OF CEMETERY OR CREMATORY United Hebrew Cemetery		22d. LOCATION (City, town, or county) (State) Washington Road, Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc.		ADDRESS 2100 Eutaw Place, Baltimore, Md.	
24a. REC'D BY REGISTRAR OCT 21 1957		24b. REGISTRAR'S SIGNATURE Harvey L. Farber	

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10257

10277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>2015 Annapolis Rd</u> b. COUNTY <u>30014</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Owings Mills 12 yrs 6 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 30, Ind.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tr. School</u>		e. IS RESIDENCE FOR A FAMILY? <u>YES</u>	
3. NAME OF DECEASED (Type or print) <u>Delores Grace Agro.</u>		4. DATE OF DEATH <u>10 13 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-36</u>
9. AGE (In years lost birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inmate (Inmate)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Richard Agro</u>		14. MOTHER'S MAIDEN NAME <u>Grace Marie Ogler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[Illegible]</u>	
17. INFORMANT <u>Inmate</u>		18. ADDRESS <u>Owings Mills, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>526x Broncho-Pneumonia (Bronchiectasis)</u> DUE TO (b) <u>Chronic Sinusitis</u> DUE TO (c) <u>Chronic Sinusitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 years</u> <u>Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Otitis media, Suppurative - Left</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>13 Oct 1957</u> to <u>13 Oct 1957</u> that I last saw the deceased alive on <u>13 Oct 1957</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.		ADDRESS (Street, city or town, state) <u>Owings Mills, Md</u> DATE SIGNED <u>10/13/57</u>	
PHYSICIAN'S NAME (Type) <u>HARRY G. BUTLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>OCT 15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE MEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON BLVD MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Illegible]</u> ADDRESS <u>1700 E Lombard St</u>		24a. REC'D BY REGISTRAR <u>15 1057</u>	24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. S.

OCT 15 1937

RECEIVED

10278

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				c. LENGTH OF STAY IN 1b <i>55</i> <i>Towson</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>317 Overbrook Road</i>				e. STREET ADDRESS <i>317 Overbrook Road</i>			
3. NAME OF DECEASED (Type or print) <i>Mr. Dominic A. Amatulli</i>				4. DATE OF DEATH Month <i>October</i> Day <i>24th</i> Year <i>19 57</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 24, 1885</i>	9. AGE (In years last birthday) <i>72</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoe Repair</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Noci, Italy</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Veto Amatulli</i>				14. MOTHER'S MAIDEN NAME <i>Angela Bruno</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Mary Amatulli, 317 Overbrook Road.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Stomach</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-19</i> , 19 <i>57</i> , to <i>10-24</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>10-24</i> , 19 <i>57</i> , and that death occurred at <i>9:45</i> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Alfred G. Ossman, Jr. M.D.</i>				ADDRESS (Street, city or town, state) <i>1101 St. Paul Street</i>		DATE SIGNED <i>10/24/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Alfred G. Ossman, Jr.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/ 1/ 57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Rubik</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>28 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10259

10279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yrlmthl3dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) unknown	
3. NAME OF DECEASED (Type or print) First Irving Middle Emerson Last Amos		4. DATE OF DEATH Month October Day 3 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-30-1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1917 (If yes, give year or dates of service) 1917		16. SOCIAL SECURITY NO. 219-05-4231	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 19 , 19 57 , to Oct. 3 , 19 57 , that I last saw the deceased alive on Oct. 3 , 19 57 , and that death occurred at 8:45p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 10-7-57			
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL 10-7-57	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL CREMATION REMOVAL (Specify) 10-11-57		22b. DATE THEREOF 10-11-57	
22c. NAME OF CEMETERY OR CREMATORY Univ. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 14 '57	
24b. REGISTRAR'S SIGNATURE Al. Leach			

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE

1957

RECEIVED
OCT 15 1957
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10280

CERTIFICATE OF DEATH

10260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland. c. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium, Balto. Co., Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Edgemoor Road, Timonium, Md.				d. STREET ADDRESS 19 Edgemoor Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Younger Arnold				4. DATE OF DEATH Month Day Year October 19, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Hereford, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stewart Arnold				14. MOTHER'S MAIDEN NAME Anna Younger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-09-0017		17. INFORMANT Melvin H. Arnold,		Address 19 Edgemoor Rd. Timonium, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 17th 1957 , to OCT 19th 1957 , that I last saw the deceased alive on OCT 19th 1957 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M. K. Quinn M.D. 1927 York Rd. Timonium 10/20/57 PHYSICIAN'S NAME (Type) M KEVIN QUINN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Foster Cemetery		22d. LOCATION (City, town, or county) (State) Hereford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Tauson, Inc.				ADDRESS 1050 York Rd.		24a. REC'D BY REGISTRAR DATE OCT 22 '57	
				24b. REGISTRAR'S SIGNATURE W. Leach			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALA.		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS		TENNESSEE		UNITED STATES		SHOOTING		HOMICIDE		100-443886-100		YES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MEMBER OF CONGRESS		HIGH SCHOOL		METHODIST		MARRIED		1945		JANUARY 1, 1968		JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENN.	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS		TENNESSEE		UNITED STATES		SHOOTING		HOMICIDE		100-443886-100		YES	

BUREAU V. 3

OCT 23 1967

RECEIVED

10281

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE 47X-3	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural: Towson	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Towson 4, Maryland		STREET ADDRESS 6000 13th St. N.W.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Mabel	(Middle)	(Last) Austin	(Month) 10 (Day) 19 (Year) 57
5. SEX: 7	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: August 3, 1893 64 yrs.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): New Jersey U.S.
13. FATHER'S NAME: Alfred Paul		14. MOTHER'S MAIDEN NAME: Pauline Stengel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudowood Sanatorium	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2/27/57
(a) Immediate cause: Pulmonary Tuberculosis		
(b) Antecedent causes (s): Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(c)		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 10/5/55, 1955, to 10/19/57, 1957, that I last saw the deceased alive on 10/19/57, and that death occurred at 4:35 PM, from the causes and on the date stated above.		
SIGNATURE		DATE SIGNED
Mabel C. Gray M.D.		Eudowood Sanatorium - Towson 4, Maryland
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
BURIAL	10/19/57	Fort Lincoln Cemetery
		Hyattsville, Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
Oct. 19, 1957	Mabel C. Gray	W.W. Deal 4812 Georgia Ave NW Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 222 11-1-57 ams

10262

10282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 23 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2202 Bryant Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last AYERS		4. DATE OF DEATH Month October Day 24 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1914
9. AGE (In years last birthday) 43		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Porter		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Ayers		14. MOTHER'S MAIDEN NAME Margaret Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW II		16. SOCIAL SECURITY NO. 218-09-7110	
17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS - primary site unknown 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Biopsy, necrotic lymph node - 10/9/57		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1957 , to October 24, 1957 , and that death occurred at 12:50 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) VAH, FT. HOWARD, MARYLAND		DATE SIGNED 10/24/57	
ACTUAL SIGNATURE Irving Freeman M.D.			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/28/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland	
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles G. Cooper Funeral Home, 512 N. Carrollton Ave., Baltimore, Md.		24a. REC'D BY REGISTRAR 10/28/57	
24b. REGISTRAR'S SIGNATURE Deuson L. Parker			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

OCT 29 1957

RECEIVED

10/28/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10263 40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carroll Manor		c. LENGTH OF STAY IN 1b XO Carroll Manor	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Quickleysville, Maryland		d. STREET ADDRESS Manor Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LILLIAN C. AYRES		4. DATE OF DEATH Month October Day 16 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1892
9. AGE (in years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY pvt.	
11. BIRTHPLACE (State or foreign country) Quickleysville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry T. Ayers		14. MOTHER'S MAIDEN NAME Mary J. Quickley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Daisy G. Burke-1923 13th St. N.W.		Address Washington D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Confluent bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PART		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 10/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Longgreen Cemetery		22d. LOCATION (City, town, or county) (State) Longgreen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home-1631 Druid Hill Ave		ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Dr. Walter H. H. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH USE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10264 44

10284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 162 W. Cross Street			
3. NAME OF DECEASED (Type or print) First ROBERT Middle --- Last BARBEE				4. DATE OF DEATH Month October Day 30 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/22/94	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Fertilizer Factory			
11. BIRTHPLACE (State or foreign country) Raleigh, N. Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Steven Barbee				14. MOTHER'S MAIDEN NAME Fannie Holden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 215-05-9146			
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOPERITONEUM DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) RUPTURE OF CAPSULE OF LIVER DUE TO (c) CARCINOMA OF LIVER INTERVAL BETWEEN ONSET AND DEATH 24 HOURS UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 5:15 o. m. PM Month 10 Day 29 Year 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA				20f. (City or town) (County) (State) 8:45 PM			
21. I certify that I attended the deceased from October 29, 1957 , to October 30, 1957 , that he was deceased on October 30, 1957 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/31/57							
ACTUAL SIGNATURE Chien Weilan				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEILAN, M.D.				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph Collick				ADDRESS 1112 E. Preston St. Baltimore, Maryland			
24a. REC'D BY REGISTRAR 11/4/57				24b. REGISTRAR'S SIGNATURE Newton L. Farley			

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER		21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE		23. SIGNATURE OF CLERK		24. SIGNATURE OF NOTARY	

BUREAU V. S.

NOV 5 1957

RECEIVED

10285

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7014 Kenleigh Road</u>				d. STREET ADDRESS <u>7014 Kenleigh Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mr. Earnest Pubus Barry</u>				4. DATE OF DEATH Month <u>October</u> Day <u>29th</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>64</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Emp. Machinery</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cleveland, Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William P. Barry</u>				14. MOTHER'S MAIDEN NAME <u>Louise Hodge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Bessie M. Barry, 7014 Kenleigh Rd.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive coronary artery occlusion</u> DUE TO (c) <u>16-18 hrs?</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>0</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , to <u>Oct 29, 1957</u> , that I last saw the deceased alive on <u>Oct 29, 1957</u> , and that death occurred at <u>5:19 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore J. Graziano</u> M.D.				ADDRESS (Street, city or town, state) <u>2802 Harford Road #18</u> DATE SIGNED <u>10/30/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Theodore J. Graziano</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>NOV 4 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Metel Gray</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		YEAR [Faint text]	

BUREAU V. S.

NOV 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10266

10286

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 34014			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 2227 EUTAW PLACE			
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last BAUER				4. DATE OF DEATH Month 10 Day 28 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11.21.1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME KARL BAUER				14. MOTHER'S MAIDEN NAME REGINA STICKHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. —		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOPTYSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FAR ADVANCED PULMONARY TUBERCULOSIS 3 years DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from 3-2-1954 to 10-28-1957 , that I last saw the deceased alive on 10-28-1957 , and that death occurred at 5:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED —							
ACTUAL SIGNATURE William Newcomer M.D.							
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1957		22c. NAME OF CEMETERY OR CREMATORY Morland Memorial		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rita Wiedefeld				ADDRESS 900 E. Biddle St. OC		24a. REC'D BY REGISTRAR DATE 31 1957	
				24b. REGISTRAR'S SIGNATURE Dorothy Jewell			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		OCT 21 1957	
COUNTY		BALTIMORE	
CITY		BALTIMORE	
STREET		1234 MAIN ST	
APARTMENT		2	
ZIP CODE		21201	
DECEASED'S NAME		JOHN DOE	
AGE		45	
SEX		M	
RACE		W	
MARRIAGE		M	
OCCUPATION		Carpenter	
EDUCATION		High School	
RELIGION		Catholic	
CAUSE OF DEATH		Heart Disease	
MANNER OF DEATH		Natural	
SIGNATURE OF PHYSICIAN		[Signature]	
DATE OF SIGNATURE		OCT 21 1957	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF SIGNATURE		OCT 21 1957	

BUREAU V. 2

OCT 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10267

10287

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore</u>		c. LENGTH OF STAY IN 1b <u>21 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Baltimore Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1301 Patapsco Ave #6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE "MATILDA BEEBY</u>				4. DATE OF DEATH Month Day Year <u>Oct 30 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 JUNE 92</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Cutler</u>				14. MOTHER'S MAIDEN NAME <u>Mary T. Boeddiker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Francis J. Beeby - 301 Patapsco Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL ARREST</u> DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROSIS, Advanced, Generalized</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>INST</u> <u>undet.</u> <u>undet</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John C. Hyle</u>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem. Baltimore Md</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC.</u> BALTIMORE 13, Maryland.				24a. REC'D BY REGISTRAR <u>Nov 4 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Reysenbery</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 5

NOV 4 1957

RECEIVED

10288

CERTIFICATE OF DEATH

1026833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 20 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) Church Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Edgar Bennett		4. DATE OF DEATH Month Oct. Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumer		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bennett		14. MOTHER'S MAIDEN NAME Emma Alice Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-5683	
17. INFORMANT Mrs. Alice B. Dosh		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - prostatic - left 142.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to brain DUE TO (c) Metastasis to brain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1955 , to October 27, 1957 , that I last saw the deceased alive on October 27, 1957 , and that death occurred at 11:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence E. McWilliams M.D.		ADDRESS (Street, city or town, state) Reisterstown, Maryland DATE SIGNED October 27/1957	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 30/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive	22d. LOCATION (City, town, or county) (State) Baltimore County Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE 10-28-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN. 15, 1910	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
OCT. 20, 1957		BALTIMORE, MD.		12345		67890	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
OCT. 20, 1957		OCT. 20, 1957		OCT. 20, 1957		OCT. 20, 1957	

RECEIVED
OCT 30 1957
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Freeland</i>				c. LENGTH OF STAY IN 1b <i>x1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bentley Road</i>				d. STREET ADDRESS <i>Bentley Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Myrtle</i> Middle <i>Birkmaier</i> Lost				4. DATE OF DEATH Month <i>October</i> Day <i>22</i> Year <i>19 57</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 14, 1899</i>	
9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Henry Pfister</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>220-18-3584</i>			
17. INFORMANT <i>Mr. Samuel Joseph Birkmaier,</i>				Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>443x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> <i>5 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/26/57</i> , 19____, to <i>10/22/57</i> , 19____, that I last saw the deceased alive on <i>10/21/57</i> , 19____, and that death occurred at <i>11:30 P.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>New Freedom, York Co., Pa.</i> <i>10/23/57</i>							
ACTUAL SIGNATURE <i>Louis Schatanoff</i> M.D.				PHYSICIAN'S NAME (Type) <i>Louis Schatanoff</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/26/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>OCT 25 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Chester Sullivan</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

OCT. 25, 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10257

CERTIFICATE OF DEATH

10270 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2430 Plainfield Road		e. STREET ADDRESS 1 2430 Plainfield	
3. NAME OF DECEASED (Type or print) First Frank Middle Walter Last Bober		4. DATE OF DEATH Month October 2, Day 1957 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1907
9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto repair man		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. Balto. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Bober		14. MOTHER'S MAIDEN NAME Maryanne ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-09-8088	
17. INFORMANT Mrs. Alma Bober		Address 2430 Plainfield Road 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertension and DUE TO Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic Insufficiency DUE TO (c) Maligned Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-7-57 to 10-12-57 , that I last saw the deceased alive on 10-7-57 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 800 N. Patterson Blvd. Balt. DATE SIGNED ACTUAL SIGNATURE Fred. Blazicka M.D. PHYSICIAN'S NAME (Type) Fred. Blazicka			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 57	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Dundalk, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Guda		ADDRESS 2829 Hudson St.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE 10 OCT 7 1957 M. Kelly	

10290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nur. Home</u>				d. STREET ADDRESS <u>1614 E. Lafayette</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Braund</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1873</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY <u>—</u>	
13. FATHER'S NAME <u>George P. Braund</u>				14. MOTHER'S MAIDEN NAME <u>M. Magdelene Stiegel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Esther Snyder 523 Yarmouth Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X Hemiplegia Right.</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 57</u> , to <u>9 Oct 57</u> , that I last saw the deceased alive on <u>8 Oct 1957</u> , and that death occurred at <u>6:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Mc Greth</u>				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28md</u>			
PHYSICIAN'S NAME (Type) <u>W. E. Mc Greth</u>				DATE SIGNED <u>10/10/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 11, 57</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Immanuel Ceme</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul G. Heermann</u>				ADDRESS <u>6067 Hay Rd</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Greth</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 55	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 214 WASHINGTON AVE		d. STREET ADDRESS 214 WASHINGTON AVE	
3. NAME OF DECEASED (Type or print) Harry F. Bratten		4. DATE OF DEATH October 6 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB-10, 1903
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 10 Hours 10 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COTTAGE MAN ST. OF MARYLAND		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY-F-BRATTEN-SR		14. MOTHER'S MAIDEN NAME ISABEL PERCY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 21570-5392	
17. INFORMANT WM A. PAYNE-32 DOGWOOD DR-TOWSON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY EAST NEWMARKET		22d. LOCATION (City, town, or county) (State) EAST NEWMARKET - MD	
23. FUNERAL DIRECTOR'S SIGNATURE WM COOK-TOWSON, INC -TOWSON 4, MD		24a. REC'D BY REGISTRAR DATE 10/7/57	
24b. REGISTRAR'S SIGNATURE Mark L. [Signature]			

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

OCT 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

11/18/1957

BUREAU V. 8

OCT 17 1957

RECEIVED

10293

CERTIFICATE OF DEATH

10274 38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>311 Alabama Road</i>		d. STREET ADDRESS <i>311 Alabama Road</i>	
3. NAME OF DECEASED (Type or print) <i>WALTER BRENTON</i>		4. DATE OF DEATH <i>Oct 13 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 23, 1890</i>
9. AGE (In years last birthday) <i>67</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pharmacist</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John S. Brenton</i>		14. MOTHER'S MAIDEN NAME <i>Ella C. McCormac</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>217-26-1285</i>	
17. INFORMANT <i>Mr. Parlett Brenton</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> DUE TO (b) <i>Arteriosclerotic Cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <i>with Coronary insufficiency.</i> (c) <i>3 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260x Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 1954</i> to <i>Oct 1957</i> , that I last saw the deceased alive on <i>Oct 8, 1957</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lawrence L. Keown</i>		ADDRESS (Street, city or town, state) <i>431 EAST LAKE AVE BALTIMORE 12 Md</i>	
PHYSICIAN'S NAME (Type) <i>LAWRENCE L. KEOWN</i>		DATE SIGNED <i>140057</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 16, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>London Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Gehring Sons Co</i>		ADDRESS <i>4905 York Road</i>	
24a. RECEIVED BY REGISTRAR <i>Oct 16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Nabel Guy</i>	

OCT 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10294

CERTIFICATE OF DEATH

102753

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 39 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore, Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS 723 Dolphin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Winifred Last Buckmaster				4. DATE OF DEATH Month 10 Day 29 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/28/97	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Augustine Buckmaster (Deceased)				14. MOTHER'S MAIDEN NAME Mary Rebecca Nicholson (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Rosewood Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 500 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Acute Bronchitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy, Grand mal type INTERVAL BETWEEN ONSET AND DEATH 7 days 12 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Owings Mills, Md. DATE SIGNED 10/30/57							
ACTUAL SIGNATURE Mary B. Butler M.D.				PHYSICIAN'S NAME (Type) Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS ADDRESS Balto., 17, Md.				24a. REC'D BY REGISTRAR 10/30/57		24b. REGISTRAR'S SIGNATURE Mary Elmer	

CERTIFICATE OF DEATH

Page One of Two

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

RECEIVED
BUREAU V. E.
JCT 27 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10276

Reg. Dist. No.

35

10295

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Rural-Parkton.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prettyboy Dam Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry A. BULL</u>		4. DATE OF DEATH <u>OCT. 22 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. RD. U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Thomas Bull.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Stiffler.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Crina Talbot, Parkton Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>NOV 5 1957</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Chester L. Fulton</u>	

1
DEATH DUTY

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10277

10296 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 12				d. STREET ADDRESS 3602 Forest Hill Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3602 Forest Hill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENE Middle FRED Last BURCHETT				4. DATE OF DEATH Month October Day 17 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1884		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY stripping Weather stripping		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph G. Burchett				14. MOTHER'S MAIDEN NAME Jane Hedgpeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-32-0882A		17. INFORMANT Clara B. Burchett-3602 Forest Hill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Vaccinoma spectrum with general DUE TO the leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 57 to Oct. 17, 19 57 , that I last saw the deceased alive on Oct. 16, 19 57 , and that death occurred at 11 30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel H. Culver M.D.				ADDRESS (Street, city or town, state) 1606 Kelly Ave. Baltimore, Md. DATE SIGNED Oct 18 '57			
PHYSICIAN'S NAME (Type) Samuel H. Culver, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 10/21/57		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Parkersburg, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hghts. Ave.				24a. REC'D BY REGISTRAR Dr. Wm. E. Martin		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CERTIFICATE NO. [Faint text]		COUNTY [Faint text]		CITY [Faint text]	

BUREAU V. 1

OCT 24-57

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10278

10297

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
f. STREET ADDRESS 1742 Moreland Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SPENCER Middle M. Last CAIN		4. DATE OF DEATH Month October Day 7 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Parking Lot	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Cain		14. MOTHER'S MAIDEN NAME Eleanor Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 215-03-5774	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 434.2 DUE TO UNDIAGNOSED DISEASE OF THE LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 DAYS UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Spondylitis - Duration 9 1/2 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1957 , to October 7, 1957 , and that death occurred at 10:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George J. Papis M.D. VAH, FORT HOWARD, MARYLAND 10/7/57			
ACTUAL SIGNATURE George J. Papis M.D. PHYSICIAN'S NAME (Type) GEORGE J PIPIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS Charles R. Law Mortuary, 802-04 Madison Av., Balto Md.		24a. REC'D BY REGISTRAR 10 OCT 9 1957	
24b. REGISTRAR'S SIGNATURE L. H. Farley			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10298

CERTIFICATE OF DEATH

10279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last CAROLAN				4. DATE OF DEATH Month 10 Day 9 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/98	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY MOTEL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDWARD CAROLAN				14. MOTHER'S MAIDEN NAME ANNA MCGOVERN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 27-20-1916		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/30 , 19 57 , to 10/9 , 19 57 , that I last saw the deceased alive on 10/9 , 19 57 , and that death occurred at 11:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 10/9/57							
ACTUAL SIGNATURE William Newcomer M.D.							
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 12 1957		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St.				24a. REC'D BY REGISTRAR DATE OCT 14 1957			
				24b. REGISTRAR'S SIGNATURE Joseph Newell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 17

CERTIFICATE OF DEATH

BUREAU V. 3

OCT 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7829 Highpoint Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Augusta M. Casagrande</i>		4. DATE OF DEATH <i>October 15th 19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1, 1900</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacobi Casagrande</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Celeste J. Casagrande,</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157x CARCINOMA of PANCREAS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>GENERALIZED METASTASIS</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>ABOUT - 9 Months</i> <i>ABOUT - 6 Months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 3, 1957</i> to <i>October 15, 1957</i> , that I last saw the deceased alive on <i>October 15, 1957</i> , and that death occurred at <i>8:05p</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ernest G. Marr</i> M.D.		ADDRESS (Street, city or town, state) <i>516 Cathedral Street</i> DATE SIGNED <i>10/16/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Ernest G. Marr</i> ERNEST G. MARR, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/18/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>OCT 18 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Part First, 1957

Place of Death

MARYLAND

A full and complete statement of the cause of death should be given in the following space, and the physician should sign and certify the truth of the statement.

The physician should also state the date and place of birth of the deceased, and the date and place of death.

The physician should also state the date and place of death, and the date and place of birth of the deceased.

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The physician should also state the date and place of death, and the date and place of birth of the deceased.

BUREAU V. S.

OCT 18 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeland</u>				c. LENGTH OF STAY IN 1b <u>24 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2410 Smith Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ferdinand A Chamberlain</u>				4. DATE OF DEATH <u>Oct 9 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>car checker Penna RR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>George Chamberlain</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Dwyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mr Francis P Chamberlain</u>				Address <u>2414 Smith Ave (27)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure (Myocarditis)</u> 422.1 DUE TO <u>Arteriosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>57</u> , to <u>Oct 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>57</u> , and that death occurred at <u>5:20 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Coolahan</u> M.D.				ADDRESS (Street, city or town, state) <u>4201 Wilkens Ave</u>			
PHYSICIAN'S NAME (Type) <u>JOHN F. COOLAHAN, M.D.</u>				DATE SIGNED <u>10/10/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>10/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	
22d. LOCATION (City, town, or county) <u>Calvary</u>				22e. (State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Coolahan</u>				ADDRESS <u>901 Solinas St.</u>		24a. REC'D BY REGISTRAR <u>Dorothy Newell</u>	
24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>				DATE <u>11 1957</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John F. [illegible]</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Oct 11 1967</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
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58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
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91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

RECEIVED
OCT 11 1967
BUREAU V. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10301
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10282 Reg. Dist.

No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Fort Howard		LENGTH OF STAY (in this place) 5hrs. 15mins.		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore		3601-4 ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital Fort Howard, Maryland				STREET ADDRESS (If rural, give location) 709 Calhoun Street			
3. NAME OF DECEASED: (First) (Middle) (Last) PAUL E. CHAPMAN				4. DATE OF DEATH (Month) (Day) (Year) October 11 19 57			
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 9/26/30	9. AGE last birthday: yrs. 27	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Shoe Company		11. BIRTHPLACE (State or foreign country): South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Istah Chapman				14. MOTHER'S MAIDEN NAME: Julia Avery			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		(If Yes, give war or dates of service) Korean		16. SOCIAL SECURITY No.: 247-44-8383		17. INFORMANT & ADDRESS: Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						4 DAYS	
Immediate cause (a) FRACTURES OF PELVIS AND RIGHT FEMUR. LACERATION OF LIVER							
Antecedent cause(s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) Private Home		21c. (City or town) (County) (State) Baltimore, Maryland			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY October 7, 1957 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell out of 3rd story window			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE W. E. BARNARD, M.D.		DATE THEREOF 10-16-57		NAME OF CEMETERY OR CREMATORY Drucilla Church Cemetery		LOCATION (City, town, or county) (State) Chesterfield, S. C.	
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE REC'D BY LOCAL REG. 10/14/57		REGISTRAR'S SIGNATURE Dwison L. Parker		24. FUNERAL DIRECTOR Charles R. Law Funeral Home, 802-04 Madison Avenue, Balto., Md.	

BUREAU V. 3

OCT 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10283

10302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 OWINGS MILLS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Black and Decker</u>		d. STREET ADDRESS <u>GREENSPRING AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WASHINGTON</u> Last <u>CHENOWETH</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Black & Decker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washington B. Chenoweth</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1919-1922-2177-20-0342</u>	
17. INFORMANT <u>Mrs. Bertha A. Chenoweth, Owings Mills, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN DEATH AND DEATH <u>Sudden</u></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov. 2, 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Owings Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 4 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mabel Guynn</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 15 11 200
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOTED FOR RECORD

BUREAU V. S.

NOV 4 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G221 10-21-57 et

10284

10303

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRAY MANOR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3v01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 309 TRAPPE RD.		d. STREET ADDRESS 1216 S. HIGHLAND AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK T. CIGANEK		4. DATE OF DEATH Month Day Year OCT. 12 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 17, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY AMER. SMELT. & REFIN. CO. SLOVAKIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE CIGANEK		14. MOTHER'S MAIDEN NAME CATHERINE CIGANEK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-4452	
17. INFORMANT PETER P. CIGANEK		Address 1216 S. HIGHLAND AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho sarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic cardiovascular disease 5 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-25-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-25 , 19 57 to OCT 12 , 19 57 , that I last saw the deceased alive on OCT 12 , 19 57 , and that death occurred at 1:00 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene F. New		ADDRESS (Street, city or town, state) 7001 Morningland Dunbar	
PHYSICIAN'S NAME (Type) Eugene F. New M.D.		DATE SIGNED 10/15/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 10-16-57		22b. DATE THEREOF 10-16-57	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler		24a. REC'D BY REGISTRAR 10/15/57	
ADDRESS 901 S. CONKLING ST. BALTO., MD.		24b. REGISTRAR'S SIGNATURE Edith Turley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE, MD.

BUREAU V. 3

OCT 16 1957

RECEIVED

10304

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural: Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 30</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>				STREET ADDRESS <u>2253 Cedley Street</u>		(If rural give location)	
3. NAME OF DECEASED: (Type or Print)		(First) <u>Gary</u>		(Middle) <u>Dean</u>		(Last) <u>Clark</u>	
4. DATE OF DEATH:		(Month) <u>10</u>		(Day) <u>25</u>		(Year) <u>19 57</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>6-4/55</u>		9. AGE last birthday: IF UNDER 1 YEAR		IF UNDER 24 HRS.
			2 yrs.		Months <u>5</u>	Days	Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Lonnie Clark</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Clark</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Personal History Hospital Records, Eudowood Sanatorium</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Convulsions unknown etiology -</u>						<u>5 1/2 hrs</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>LOBULAR PNEUMONIA</u>						<u>(?)</u>	
(c) <u>CONGENITAL Aortic and mitral valve defect</u>						<u>congenital</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ? Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <u>4 - 8, 19 57</u> , to <u>10 - 25, 19 57</u> , that I last saw the deceased alive on <u>10 - 25, 19 57</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. W. Finkbeiner</u>				ADDRESS <u>Eudowood Sanatorium, Towson 4, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 28, 1957</u>		<u>Glen Haven</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-28-57</u>		<u>Mabel Gray</u>		<u>Wm. C Cook, Inc.</u>		<u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10286

CERTIFICATE OF DEATH

Reg. Dist. No.

40

10305

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. LENGTH OF STAY IN IB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P. O. Box 652 Forge Rd.		d. STREET ADDRESS 1 P. O. Box 652 Forge Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle E. Last Clayton		4. DATE OF DEATH Month October Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Ice Cream Mfg.		10b. KIND OF BUSINESS OR INDUSTRY Ice Cream	
11. BIRTHPLACE (State or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Wesley B. Clayton		14. MOTHER'S MAIDEN NAME Mary Hilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lillian B. Clayton		Address Box 652 White Marsh, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) atherosclerotic Heart Dis. DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 13 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate 6 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 8, 1957 to Oct. 13, 1957 that I last saw the deceased alive on Oct. 12, 1957 and that death occurred at 12:55 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford F. Hudson M.D.		ADDRESS (Street, city or town, state) Fork Md.	
DATE SIGNED Oct. 16, 1957			
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON, FORK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Fork M. E.	22d. LOCATION (City, town, or county) (State) Fork, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lepore, Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE 16 1957		24b. REGISTRAR'S SIGNATURE Dr. Walter Hemmety	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10287

10306

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 E. Susquehanna Avenue		/ d. STREET ADDRESS 117 E. Susquehanna Avenue	
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle COLLIER Last		4. DATE OF DEATH Month October Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 20, 1888
9. AGE (In years birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Henry W. Mische, 117 E. Susquehanna Ave.		Address Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of Liver DUE TO (c) Adenocarcinoma ascending Colon		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hemicolectomy 1955		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1955 to October 2, 1957 , that I last saw the deceased alive on October 2, 1957 , and that death occurred at 8:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 201 W Madison Street Baltimore, Md. DATE SIGNED			
ACTUAL SIGNATURE Patrick C Phelan M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Patrick C Phelan M.D.		Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 12, 1957	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Soro		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR DATE Oct 14, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		Jan 15, 1922	
Place of Birth		Cause of Death		Manner of Death		Occupation	
New York City		Heart Disease		Natural		Teacher	
Date of Death		Time of Death		Place of Death		Physician	
Oct 10, 1957		10:30 AM		Home		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

OCT 15 1957

RECEIVED

Oct 15, 1957

London, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the coroner prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b 	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Ezekiel Last Colliver		4. DATE OF DEATH Month October Day 23 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employer		10b. KIND OF BUSINESS OR INDUSTRY Title Finance Co.	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses C. Colliver		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 215-03-4582	
17. INFORMANT Mrs. Pauline Colliver		Address Baltimore Rd. 3711 Reisterstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 minutes 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D.D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D.D. Caples, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 10-23-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sal Svenson		ADDRESS 1124 W. North St.	
24a. REC'D BY REGISTRAR 25 1957		24b. REGISTRAR'S SIGNATURE Donna J. Jewell	

RECEIVED

OCT 25 1957

BUREAU V. 5

RECEIVED
OCT 25 1957
BUREAU V. 5

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tr. School</u>		d. STREET ADDRESS <u>7406 EDSWORTH RD</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Robert</u> Last <u>Colwell</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Matthew R. Colwell</u>		14. MOTHER'S MAIDEN NAME <u>Betty Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MATTHEW COLWELL</u>		Address <u>7406 EDSWORTH RD</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonitis</u> DUE TO <u>753.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>—</u> (b) <u>Congenital Cerebral Disgenesis</u> DUE TO <u>—</u> (c) <u>and Malnutrition.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492x Mental Retardation, Spastic Quadriplegia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-15, 1957</u> , to <u>10/20-1957</u> , that I last saw the deceased alive on <u>10-20-1957</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Rosewood State Training School</u>		DATE SIGNED <u>10/20/57</u>	
ACTUAL SIGNATURE <u>George C. Medairy</u>		M.D. <u>Owings Mills, Md</u>	
PHYSICIAN'S NAME (Type) <u>George C. Medairy MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT CARMEL CEM</u>	22d. LOCATION (City, town, or county) (State) <u>O'DONNELL ST MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suppl Bro</u>		ADDRESS <u>1800 E LOMBARD ST</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1892		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1915		BALTIMORE, MD.		JANE HARRIS		OCT 22 1957		BALTIMORE, MD.	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
LABORER		OCT 22 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345	
EDUCATION		DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		DATE OF BURIAL		PLACE OF BURIAL	
HIGH SCHOOL		OCT 25 1957		BALTIMORE, MD.		JOHN J. HARRIS		OCT 25 1957		BALTIMORE, MD.	
RELIGION		DATE OF REGISTRATION		PLACE OF REGISTRATION		NAME OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE	
CATHOLIC		OCT 22 1957		BALTIMORE, MD.		J. H. HARRIS		OCT 22 1957		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE	
J. H. HARRIS		OCT 22 1957		BALTIMORE, MD.		J. H. HARRIS		OCT 22 1957		BALTIMORE, MD.	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE	
J. H. HARRIS		OCT 22 1957		BALTIMORE, MD.		J. H. HARRIS		OCT 22 1957		BALTIMORE, MD.	

BUREAU V. 2

OCT 22 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10309

CERTIFICATE OF DEATH

10290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 18 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle E. Last CONNELLY				4. DATE OF DEATH Month October Day 27 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1903		9. AGE (In years last birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael J. Connelly				14. MOTHER'S MAIDEN NAME Melinda Grainer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 217-11-6268		17. INFORMANT Clin Rec. Vet. Adm Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA; HYDROTHORAX, XXXXX RIGHT, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCITES DUE TO ARTERIOSCLEROTIC HEART DISEASE (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct. 9 , 19 57 , to Oct. 27 , 19 57 . XXXXXX I have seen the body of the deceased and that death occurred at 11:55AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, Fort Howard, Md. 10/28/57							
ACTUAL SIGNATURE Chien Wei Lan		M.D. VAH, Fort Howard, Maryland					
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		VAH, FORT HOWARD, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan & Son		ADDRESS Hollins & Poppleton Baltimore, Maryland		24a. REC'D BY REGISTRAR Oct 29 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

NAME OF DECEASED: *John J. [illegible]*
AGE: *45* SEX: *M*
DATE OF BIRTH: *1912*
PLACE OF BIRTH: *[illegible]*
OCCUPATION: *[illegible]*
CAUSE OF DEATH: *[illegible]*
DATE OF DEATH: *1957*
PLACE OF DEATH: *[illegible]*
SIGNATURE OF PHYSICIAN: *[illegible]*
SIGNATURE OF REGISTRAR: *[illegible]*

BUREAU V. S.

OCT 29 1957

RECEIVED

[Handwritten signatures and initials]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10310

CERTIFICATE OF DEATH

10291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 7 Hours, 12M.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2912 Woodland Avenue			
3. NAME OF DECEASED (Type or print) First MICHAELANGELO Middle F. Last CONVERSO				4. DATE OF DEATH Month October Day 11 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 21, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Musician-Teacher		10b. KIND OF BUSINESS OR INDUSTRY Band and Orchestra		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Paul Converso				14. MOTHER'S MAIDEN NAME Carnela Lombardi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 215-28-7832		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF HEART WITH CARDIAC TAMPONADE DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS (c) 3 DAYS						INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from October 10, 1957 , to October 11, 1957 and that death occurred at 2:42A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/11/57							
ACTUAL SIGNATURE Chien Wei-Lan M.D. VAH, FORT HOWARD, MARYLAND 10/11/57							
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-15-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Wm Cook-Blight, Inc. 6009 Harford Rd. Balto. 24, Md.				24a. REC'D BY REGISTRAR 10/16/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, TO

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES E. BROWN		45		M		W		1912		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE		LABORER		HEART DISEASE		NATURAL		OCT 15 1957		BALTIMORE, MD.	
FATHER		MOTHER		BORN		DIED		BURIED		INTERMENT	
JAMES E. BROWN		MARY E. BROWN		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
OCT 15 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		OCT 15 1957		BALTIMORE, MD.	
FATHER		MOTHER		BORN		DIED		BURIED		INTERMENT	
JAMES E. BROWN		MARY E. BROWN		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	

BUREAU V. 2

OCT 17 1957

RECEIVED

10311

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Baltimore-Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8122 Hillendale Road</u>		d. STREET ADDRESS <u>8122 Hillendale Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>MAY</u> Last <u>COULTER</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Unverzagt</u>		14. MOTHER'S MAIDEN NAME <u>Janette Collison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. William Jones</u>		Address <u>3601 Southern Ave. 14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>October</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 26</u> , 19 <u>57</u> , and that death occurred at <u>3:15 P.</u> M, from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <u>Loy M. Zimmerman</u> M.D.		ADDRESS (Street, city or town, state) <u>3202 Hartford Rd Baltimore - 18, Md</u>	
PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 7, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		ADDRESS <u>4210 Belair Road</u>	
24a. REC'D BY REGISTRAR <u>Oct 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. H. M. Bacon</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10312

CERTIFICATE OF DEATH

10293

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 5 Hours 35 M.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 1701 Madison Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last COX, JR.				4. DATE OF DEATH Month October Day 17 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 15, 1924	
9. AGE (In years last birthday) 33		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Greenville, N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John M. Cox, Sr.				14. MOTHER'S MAIDEN NAME Elizabeth Thorpe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 219-18-6939		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, BILATERAL 490x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OBESITY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4 DAYS UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 17, 1957 , to October 17, 1957 , and that death occurred at 6:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/18/57 ACTUAL SIGNATURE Chen Wei Fan PHYSICIAN'S NAME (Type) VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home, 1631 Druid Hill Ave.				24a. REC'D BY REGISTRAR OCT 22 1957		24b. REGISTRAR'S SIGNATURE L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

RECEIVED
OCT 22 1957
BURKAY V. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10294

10313

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 111 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1634 Aisquith Street			
3. NAME OF DECEASED (Type or print) First DOUGLAS Middle C. Last CRIM				4. DATE OF DEATH Month October Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1931	
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hardware Store		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James R. Crim				14. MOTHER'S MAIDEN NAME Mary Pentz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean				16. SOCIAL SECURITY NO. 213-28-4491		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUMOR OF THE FRONTOPIRIETAL LOBE, RIGHT SIDE, 193x XXXXX ASTROCYTOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LEFT HEMIPLEGIA DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Craniotomy (operation) 7/8/57							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour VA Month 19 Day 19 Year 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from June 19, 1957 , to October 8, 1957 . XXXXXX and that death occurred at 5:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/8/57							
ACTUAL SIGNATURE Milton Ginsberg				PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D., Acting Chief, Surgical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc., St. Paul and Preston Sts., Balto. Md.				24a. REC'D BY REGISTRAR DATE 10/9/57		24b. REGISTRAR'S SIGNATURE Lewson L. Farber	

RECEIVED

OCT 10 1957

BUREAU VI

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10295
10314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>20 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>343 Hillen Road Towson 4, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson, Maryland</u> d. STREET ADDRESS <u>343 Hillen Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alonzo W. Davis</u>		4. DATE OF DEATH <u>October 17, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 27, 1897</u>
9. AGE (in years last birthday) <u>59 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ridge Spring, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alonzo Davis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>George Davis</u>		Address <u>343 Hillen Rd. Towson, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic M. tr. / Lesion</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Chronic Decompensation</u> DUE TO <u>Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>25 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-21-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto.-National</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Rd. Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leroy O. Dyett</u>		ADDRESS <u>946 Pennsylvania</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Hubel Guy</u>	

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2. may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the arrangements prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10315

CERTIFICATE OF DEATH

1029631
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6219 Liberty Heights Terr		d. STREET ADDRESS 6219 Liberty Heights Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Russell Earl Diehl		4. DATE OF DEATH Month Day Year October 13, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1892
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundryman		10b. KIND OF BUSINESS OR INDUSTRY Bedford Co. Pa.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jesse Diehl		14. MOTHER'S MAIDEN NAME Mary Messersmith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-16-0900A	
17. INFORMANT Address Mildred Ruth Diehl 6219 Liberty Heights Terrace			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic DUE TO Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/13, 19 57 to 10/13, 19 57 , that I last saw the deceased alive on 10/13, 19 57 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7013 Liberty Road Balto. 7, Md. DATE SIGNED			
ACTUAL SIGNATURE L. H. Gilmore M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16, 1957	
22c. NAME OF CEMETERY OR CREMATORY Shreves Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Bedford County Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Elesworth ADDRESS 4600		24a. REC'D BY REGISTRAR 10/13/57 24b. REGISTRAR'S SIGNATURE Dr. Hm. E. Marting	

CERTIFICATE OF DEATH

BUREAU V. 3

OCT 24 1957

RECEIVED

10316

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 9 Baltimore 14)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1321 Taylor Avenue				d. STREET ADDRESS 1321 Taylor Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle Digman Last Digman				4. DATE OF DEATH Month October Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1902	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus owner-operator				10b. KIND OF BUSINESS OR INDUSTRY Bus route -public		11. BIRTHPLACE (State or foreign country) W. Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Abson Digman				14. MOTHER'S MAIDEN NAME Sarah Clemm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 377-16-3709		17. INFORMANT Family Records	
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of colon DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 8 , 19 57 , to Oct 1 , 19 57 that I last saw the deceased alive on Sept 30 , 19 57 , and that death occurred at 6 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9660 Belair Rd. Baltimore -6- Maryland DATE SIGNED Oct 1, 1957							
ACTUAL SIGNATURE George D. Edwards M.D.							
PHYSICIAN'S NAME (Type) George D. Edwards							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Carmel, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burne Lono ADDRESS Towson, Maryland				24a. REC'D BY REGISTRAR Oct. 4, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10010

PLACE OF BIRTH

Religious

Married

Occupation

Definition

London, England

44

London

101 Taylor Avenue

1951

101

Age

44

October

White

1902

44

His name - George

His name - George

His name - George

His name - George

His name - George

His name - George

His name - George

His name - George

His name - George

BUREAU V. S.

OCT 7 1957

RECEIVED

10317

CERTIFICATE OF DEATH

10298

Reg. Dist. No.

23

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CECIL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON 0721.2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TRAINING SCHOOL			d. STREET ADDRESS 244 WEST HIGH STREET		
3. NAME OF DECEASED (Type or print) First DOUGLAS Middle STERN Last DILKS			4. DATE OF DEATH Month 10 Day 26 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-55		9. AGE (In years last birthday) 2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) ELKTON, MARYLAND	
13. FATHER'S NAME VERNON STERN DILKS			14. MOTHER'S MAIDEN NAME ANN WILLLOWBY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ROSEWOOD RECORDS OWINGS MILLS MD	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) obstruction of lower airways by mucus & Food (c) respiratory difficulties due to extensive scarring of the brain						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Extensive scarring of the brain due to hypoxia during illness at 3 months of age							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part for Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Rich. Lindenberg (Path.) M.D.							
PHYSICIAN'S NAME (Type) Rich. Lindenberg (Pathologist)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/30/57		ELKTON Cemetery		ELKTON MD	
23. FUNERAL DIRECTOR'S SIGNATURE Walter de Boer, Jr.				ADDRESS Elkton, Md.		24. REC'D BY REGISTRAR DATE 10/30/57	
24b. REGISTRAR'S SIGNATURE Mary Elmer							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

OCT 30 1957

RECEIVED

10318

CERTIFICATE OF DEATH

1029933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 17 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1102 Parrish Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Dodd				4. DATE OF DEATH Month 10 Day 17 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/33	
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 2 Days 18		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Oscar T. Dodd				14. MOTHER'S MAIDEN NAME Lucy Katherine Jordan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 		17. INFORMANT Rosewood Records Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Congestive heart failure DUE TO Rheumatic mitral heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 days 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic fever (1949)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/17 , 19 57 to 10/17 , 19 57 that I last saw the deceased alive on 10/17 , 19 57 , and that death occurred at 6:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry G. Butler M.D.				ADDRESS (Street, city or town, state) Owings Mills, Md DATE SIGNED 10/18/57			
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.				INSTITUTION Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1957		22c. NAME OF CEMETERY OR CREMATORY Rockville Union		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Thompson ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR OCT 21 1957		24b. REGISTRAR'S SIGNATURE Mary Elmes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 2

OCT 21 1957

RECEIVED

Rockville Union

10/30/1957

Register

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10300

10319

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		STATE <u>Md.</u>		COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		LENGTH OF STAY (in this place) <u>13 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>McHenry Road</u>				STREET ADDRESS (If rural give location) <u>Mc Henry Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Howard</u> (Middle) <u>A.</u> (Last) <u>Dorsey</u>				(Month) <u>Oct.</u> (Day) <u>25</u> (Year) <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 20, 1904</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Litsinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>217-01-9734</u>		17. INFORMANT & ADDRESS <u>Mrs. Adele B. Dorsey Mc Henry Road</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.1 IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma of Neck</u>						INTERVAL BETWEEN ONSET AND DEATH <u>17 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Origin undetermined</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>UNDERLYING CAUSE LAST.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>May 21, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Metastatic Ca. of Neck. orig in undetermined</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 19 56</u> , to <u>Oct 25 57</u> , that I last saw the deceased alive on <u>October 25 57</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James A. Miller M.D.</u>				DATE SIGNED <u>10/26/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-28-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR DATE <u>10/24/57</u>		REGISTRAR'S SIGNATURE <u>Dorothy E. Newell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lowmyer</u>		ADDRESS <u>5005 Park Heights Ave</u>	

CERTIFICATE OF DEATH

10879

Form 10-14

1. PLACE THE DEATH		2. NAME OF DECEASED	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. PLACE OF BIRTH		8. DATE OF BIRTH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	

BUREAU V. S.

OCT 30 1957

RECEIVED

SMOKELESS

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be filled with
page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10265
CERTIFICATE OF DEATH

10301

Reg. Dist. No. 47

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1236 Maiden Choice		d. STREET ADDRESS 1236 Maiden Choice	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stella Middle M. Last Douglass		4. DATE OF DEATH Month Oct. Day 5. Year 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 24, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Yinger		14. MOTHER'S MAIDEN NAME Anna -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Benjamin Douglass, 1236 Maiden Choice La	
17. INFORMANT Benjamin Douglass, 1236 Maiden Choice La		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 56 , to Oct 5 , 19 57 , that I last saw the deceased alive on Oct 3 , 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4001 Wilkens Ave DATE SIGNED 10-8-57 ACTUAL SIGNATURE I Earl Pass MD PHYSICIAN'S NAME (Type) I EARL PASS, M.D. Balto 29 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24. REC'D BY REGISTRAR Oct 9 1957	
25. REGISTRAR'S SIGNATURE Dr. J. M. Kuffner			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

10-28

RECEIVED
OCT 9 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10320

Items 8, 11, 14, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

Reg. Dist. No.

10302

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bond Ave.		d. STREET ADDRESS / Bond Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Golden B. Downie		4. DATE OF DEATH Month Day Year Oct. 18 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890 Jan. 20, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Alexander		14. MOTHER'S MAIDEN NAME Harriet Elizabeth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 273-16-6759	
17. INFORMANT Mrs. R. C. Vanderbosch		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Gall Bladder DUE TO (c) Diabetes 260X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes 260X INTERVAL BETWEEN ONSET AND DEATH 4 mos. 15 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 8-7-56 , 19 56 , to 10-18-57 , 19 57 , that I last saw the deceased alive on Oct. 16 , 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 10-19-57			
ACTUAL SIGNATURE D. D. Caples		M.D. D. D. Caples	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 21, 57	
22c. NAME OF CEMETERY OR CREMATORY Homewood Cemetery		22d. LOCATION (City, town, or county) (State) Pittsburg Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE 10-19-57		24b. REGISTRAR'S SIGNATURE D. D. Caples	

CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - LITTLE ROCK, ARK.

10-10-1957

Name of Deceased		Date of Death	
John A. Jones		10-10-1957	
Place of Birth		Place of Death	
Little Rock, Ark.		Little Rock, Ark.	
Age		Sex	
45		Male	
Race		Occupation	
White		Teacher	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Artery Disease	
Duration of Illness		Date of Admission to Hospital	
10 Days		10-01-1957	
Name of Physician		Name of Hospital	
Dr. J. B. Smith		St. John's Hospital	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

OCT 27 1957

RECEIVED

Arkansas State Department of Health

Little Rock, Arkansas

CERTIFICATE OF DEATH

10303

Reg. Dist. No.

10321

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME</u>		d. STREET ADDRESS <u>3606 NINTH ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>TDA</u> Middle <u>DUFFEY</u> Last <u>DUFFEY</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u> <u>APR. 22, 1886</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Kirby</u>		14. MOTHER'S MAIDEN NAME <u>LAURA MAGAHA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>DANIEL H. DUFFEY</u>		Address <u>Box 8 Ft. Smallwood Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1957</u> to <u>Oct 14, 1957</u> , that I last saw the deceased alive on <u>Oct 12, 1957</u> , and that death occurred at <u>6:03 AM</u> ; from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff</u> M.D.		ADDRESS (Street, city or town, state) <u>CLIFF RATLIFF, SR. 10715/57</u>	
PHYSICIAN'S NAME (Type) <u>4605 EDMONDSON AVE BALTIMORE 29, Md.</u>		DATE SIGNED <u>10/15/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 17, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>RITCHIE Hgwy. N.A.G., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Goral</u>		ADDRESS <u>4001 Ritchie Hwy</u>	
24a. REC'D BY REGISTRAR <u>Oct 21 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 and 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 21 1957

RECEIVED

10322

CERTIFICATE OF DEATH

10304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Md.		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Maple Ave.		d. STREET ADDRESS 104 Maple Ave.	
3. NAME OF DECEASED (Type or print) First Louis Middle J. Last Einolf		4. DATE OF DEATH Month October Day 25 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Mullineaux	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Einolf		14. MOTHER'S MAIDEN NAME Jennie Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Elsie Nugent		Address 4916 Gateway Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Sudden 8 yrs -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 1957 to Oct 25, 1957 that I last saw the deceased alive on Oct 25, 1957 and that death occurred at 2:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Victor F. King M.D.		ADDRESS (Street, city or town, state) Catonsville, Md.	
PHYSICIAN'S NAME (Type) Victor F. King		Catonsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 28, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Ave. Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE SCHWEINSBERG FUNERAL SERVICE		ADDRESS 1126 W. Cross St.	
24a. REC'D BY REGISTRAR OCT 29 57		24b. REGISTRAR'S SIGNATURE Reich	

1126 W. Cross St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

OCT 29 1957

RECEIVED

COMPLAINT BOARD

10323

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River, Md.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>238 Riverthorn Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Benjamin</u> Last <u>Elliott Jr.</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1949</u>	9. AGE (In years last birthday) <u>8</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltio., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Benjamin Elliott Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>James B. Elliott Sr.</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMANGIO-ENDOTHELIO SARCOMA, LEFT THIGH</u> <u>197X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WITH METASTASES TO LUNGS</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT</u> , 19 <u>54</u> , to <u>OCT 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>OCT 30</u> , 19 <u>57</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2108 CREMS RD</u> <u>10/30/57</u> ACTUAL SIGNATURE <u>Louis Semenov</u> M.D. <u>BALTIMORE 20, MD</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Bugdzinski</u>				ADDRESS <u>407 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>1</u> 19 <u>57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

RECEIVED
NOV 2 1937
BUREAU V. B.
Louis S. [illegible]
Oct 30 27
2108 Chestnut St
24 - Oct 30 27

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10258

CERTIFICATE OF DEATH

10306

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> Dundalk MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 129 Sollers Point Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Turner Station	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Malcolm Embrey		4. DATE OF DEATH Month Day Year October 29 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Midland, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Embrey		14. MOTHER'S MAIDEN NAME Mary Embrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-0319	
17. INFORMANT William Embrey		Address 129 Sollers Point Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary Thrombosis Hypertension & arteriosclerosis unknown INTERVAL BETWEEN ONSET AND DEATH 1 day.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 28/57</u> 19 <u>57</u> , to <u>Oct 29/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>October 29</u> 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 107 N. Main St. Baltimore 11/1/57	
ACTUAL SIGNATURE J. H. Thomas		M.D.	
PHYSICIAN'S NAME (Type) J. H. Thomas M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1957	
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		22d. LOCATION (City, town, or county) (State) Ann Arundel Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	
24a. REC'D BY REGISTRAR DATE NOV 4 1957		24b. REGISTRAR'S SIGNATURE M. Kelly	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

10324

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Maryland 55			
f. STREET ADDRESS 3522 St. James Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle M. Last Ferris				4. DATE OF DEATH Month October Day 3 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 89?		10. IF UNDER 1 YEAR Months 89? Days 89? Hours 89? Min. 89?		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
13. FATHER'S NAME William Ferris				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE State HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 14 , 19 57 , to Oct. 3 , 19 57 that I last saw the deceased alive on Oct. 3 , 19 57 , and that death occurred at 12:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 10-3-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Oct. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Boyman & Sons				24a. REC'D BY REGISTRAR 10-3-57			
24b. REGISTRAR'S SIGNATURE Mary B. Strie							

OCT 7 '57

R. H. Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10325

CERTIFICATE OF DEATH

10308

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4			
f. STREET ADDRESS 217 WEST 27th STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM J. FORREST		First Middle Last		4. DATE OF DEATH October 19, 1957		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-30-98	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Wesley Forrest				14. MOTHER'S MAIDEN NAME Anna Elizabeth Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 215-09-2024		17. INFORMANT Address Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Cirrhosis of Liver Laennec's 581.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (2) Pulmonary Infarct Recent Left Lower Lobe (3) Esophageal Varices Vistal						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from October 8, 1957 , to October 19, 1957 , and that death occurred on October 19, 1957 at 12:45 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 10/19/57							
ACTUAL SIGNATURE Rolando Ponce de Leon		M.D. Veterans Administration Hospital 10/19/57					
PHYSICIAN'S NAME (Type) ROLANDO PONCE DE LEON, M. D.		Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/57		22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc				24a. REC'D BY REGISTRAR DATE 10/13/57		24b. REGISTRAR'S SIGNATURE Dawson L Farley	

VS A15 (4)
15M 9/55

WILLIAM COOK-BLIGHT INC. 6009 Harford Road, Balto., Md.

RECEIVED

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

103098

Reg. Dist. No.

10326

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibson Island 02x0.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle B. Last FRENCH				4. DATE OF DEATH Month Oct. Day 2, Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1870	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Md.							
13. FATHER'S NAME - Henry Eben				14. MOTHER'S MAIDEN NAME Amanda - Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. George French - Gibson Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA URINARY BLADDER 181X DUE TO GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INTESINAL OBSTRUCTION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH JUNE 1957			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JANUARY 1956, to OCT. 2 1957, that I last saw the deceased alive on OCTOBER 1 , 1957, and that death occurred at 2:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Kennedy Waller M.D.				ADDRESS (Street, city or town, state) 3500 N. Calvert Street DATE SIGNED OCT. 4, 1957			
PHYSICIAN'S NAME (Type) W. Kennedy Waller, M. D.				Baltimore 18, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/57		22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schaefer & Sons				ADDRESS BALTO 17th		24a. REC'D BY REGISTRAR OCT 7 1957	
				24b. REGISTRAR'S SIGNATURE Mabel Gray			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 2 1957

RECEIVED

10327

CERTIFICATE OF DEATH

10310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 13x2.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 116 Columbia Rd.			
3. NAME OF DECEASED (Type or print) WILLIAM First HOWARD Middle FREY Last				4. DATE OF DEATH Month 10 Day 19 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1879	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Woollen Mill		11. BIRTHPLACE (State or foreign country) Oella, Md	
13. FATHER'S NAME Henry Frey				14. MOTHER'S MAIDEN NAME Mitche Ridgely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ?		17. INFORMANT Stanley Frey, Catonsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2608 Diabetes Mellitus 2. Arteriosclerosis Cardiovascular						INTERVAL BETWEEN ONSET AND DEATH 7 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 9/12 , 19 57 , to 9/19 , 19 57 , that I last saw the deceased alive on 10/19 , 19 57 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James E. Rowe M.D. 10/21/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James E. Rowe Catonsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-57		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higginbotham				24a. REC'D BY REGISTRAR OCT 23 '57		24b. REGISTRAR'S SIGNATURE W. E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 23 1957

RECEIVED

10328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Monkton</u>				c. LENGTH OF STAY IN 1b <u>15 months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural x0 Monkton</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Blue Mount Rd.</u>				d. STREET ADDRESS <u>Blue Mount Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Clarence Fried</u>				4. DATE OF DEATH Month Day Year <u>October 10 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna Railroad</u>			
11. BIRTHPLACE (State or foreign country) <u>York, Penn</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Marcellus Fried</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT Address <u>Pauline Heaps Monkton, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>57</u> , to <u>Oct 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>57</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>Pt 15 MON, Md</u> DATE SIGNED <u>10/11/57</u>			
PHYSICIAN'S NAME (Type) <u>H. M. FRANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 14 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HENRY SANDER & SONS, INC. Baltimore Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Oct 15 57</u>		24b. REGISTRAR'S SIGNATURE <u>Pauline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10312

10329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1111 Briscoe Street	
3. NAME OF DECEASED (Type or print) First BEN Middle -- Last GADSDEN		4. DATE OF DEATH Month October Day 24 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	
11. BIRTHPLACE (State or foreign country) St. George, South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Shuler Gadsden		14. MOTHER'S MAIDEN NAME Vic (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 251-01-4481	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO ARTERIO-SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks Undetermined	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that x attended the deceased from October 3 , 19 57 to October 24 , 19 57 . that he was the deceased and that death occurred at 9:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Irving Freeman M.D.			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief, Medical Service VAH Ft. Howard, Md 10/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy C. Wilson		24a. REC'D BY REGISTRAR DATE 10/29/57	
ADDRESS 601 Hamburg St. Balto. Md		24b. REGISTRAR'S SIGNATURE Lawson L. Farley	

100

BUREAU V. 5

1957 OCT 30

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10330

CERTIFICATE OF DEATH

10313

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Baltimore Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS 24 W. Pennsylvania Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARTHA LEE GARDINER		4. DATE OF DEATH Month Day Year October 20, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Washington Stevenson		14. MOTHER'S MAIDEN NAME Anna W. Gatch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491x (b) GENERAL DEBILITY (c) FRACTURE LEFT FEMORAL NECK INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 6 WKS 6 WKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7:00 p. m. 9 4 1957		20d. INJURY OCCURRED - While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) TOWSON BALT. MD.	
21. I certify that I attended the deceased from 3/31 , 19 51 , to 10/20 , 19 57 , that I last saw the deceased alive on 10/20 , 19 57 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald L. Somerville		ADDRESS (Street, city or town, state) 25 W Pennsylvania Ave	
PHYSICIAN'S NAME (Type) Donald L. Somerville		DATE SIGNED 10/21/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Towson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR Oct. 23, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10331

CERTIFICATE OF DEATH

10314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3mths 13dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 4836 Park Heights Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emma Middle Tuerke Last Garrison				4. DATE OF DEATH Month October Day 30 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Adolph Tuerke				14. MOTHER'S MAIDEN NAME Caroline Apple			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration DUE TO (c) Senile brain disease				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 8, 19 57 , to Oct. 30, 19 57 , that I last saw the deceased alive on Oct. 30, 19 57 , and that death occurred at 6:15p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Gertrude J. Fleischmann M.D. SPRING GROVE STATE HOSPITAL 10-31-57 PHYSICIAN'S NAME (Type) Gertrude Fleischmann, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. ADDRESS 1217 St. Paul St.				24a. REC'D BY REGISTRAR DATE NOV 4 57		24b. REGISTRAR'S SIGNATURE Oct 31 1957	

BUREAU V. S.

NOV 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 221 10-9-57 et

10332

CERTIFICATE OF DEATH

10315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>Parkville</u> <u>x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2900 Linganore Avenue</u>		d. STREET ADDRESS <u>2900 Linganore Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mr. John</u> Middle <u>Gehring</u> Last <u>Gehring</u>		4. DATE OF DEATH Month <u>October</u> Day <u>2nd</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/64</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Adams County, Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>"Unknown by family"</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Lawrence(dec)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>John Gehring 2900 Linganore Ave.</u>	
17. INFORMANT Address <u>John Gehring 2900 Linganore Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 yr.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/14/57</u> , 19 <u>57</u> , to <u>10/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/1/57</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold A. Grott</u> M.D. <u>8100 Harford Road</u>		DATE SIGNED <u>10/2/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Harold A. Grott</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>		24. REC'D BY REGISTRAR <u>10/4 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Bacon</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

6

NAME OF DECEASED John George 2900 Langhorne Ave.		DATE OF DEATH 1957	
AGE 25		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Student		MARRIAGE Never	
PLACE OF BIRTH Johns Creek, Adams County, Penna.		DATE OF BIRTH 1932	
PLACE OF DEATH Johns Creek, Adams County, Penna.		DATE OF DEATH 1957	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN Johns Creek, Adams County, Penna.		SIGNATURE OF DEATH REGISTRAR Johns Creek, Adams County, Penna.	

RECEIVED
OCT 4 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filled with
the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10316

10333

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 59 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 0913.2	
f. STREET ADDRESS 34 Park Lane		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle A. Last GILBERT		4. DATE OF DEATH Month October Day 24 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Company	
11. BIRTHPLACE (State or foreign country) Madison, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leo Gilbert		14. MOTHER'S MAIDEN NAME Mary Hooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 220-10-6012	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL 141X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF TONGUE WITH METASTASIS DOCK DUE TO (c) 2 YEARS		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 26, 1957 to October 24, 1957 and that death occurred at 7:23A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/24/57			
ACTUAL SIGNATURE Chien Wei Lan		M.D. VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-57	
22c. NAME OF CEMETERY OR CREMATORY Madison Cemetery		22d. LOCATION (City, town, or county) (State) Madison, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS Charles R. Law Mortuary, 802-04 Madison Ave. Baltimore 1, Md.	
24a. REC'D BY REGISTRAR DATE Oct. 28-57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. 5

OCT 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or other disposal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northbrook</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		e. STREET ADDRESS <u>17725 Eastdale Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Griffiths</u> Last <u>Griffiths</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30-1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Simmons</u>		14. MOTHER'S MAIDEN NAME <u>2.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. J. Griffiths</u> Address <u>Above (Son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>00</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>St. Clair Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u> ADDRESS <u>East</u>		24a. REC'D BY REGISTRAR <u>Nov 1</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Davis</u>	

RECEIVED

NOV 1 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

NORA GUNSALLUS

10335 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River - MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River Md x2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2205 Balcan Ave</u>				d. STREET ADDRESS <u>2233 OLD EASTERN AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Gunsollus</u> Last				4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 31-1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>210-18-8885</u>			
17. INFORMANT <u>PAUL MILLER, 2233 Old Eastern Ave</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>CHRONIC MYOCARDITIS</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause lost. DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10/16/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elbernezers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto county Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Christine Brudzinski</u>				24a. REC'D BY REGISTRAR <u>DET 21 1957</u>			
ADDRESS <u>1407 Eastern Ave</u>				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

46

RECEIVED
OCT 21 1957
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G222 10-29-57 et

CERTIFICATE OF DEATH

10336

10319

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines		d. STREET ADDRESS Pasadena 02x0.2	
3. NAME OF DECEASED (Type or print) First Chester Middle W. Last Haile		4. DATE OF DEATH Month 10 Day 22 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1883
9. AGE (In years last birthday) 73 7/8 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Rep.		10b. KIND OF BUSINESS OR INDUSTRY Otis Elevator Co. Baltimore County	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Haile		14. MOTHER'S MAIDEN NAME Elizabeth Slade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Chester W. Haile, Jr. 1586 Harvard Rd., N. Atlanta, Ga.	
17. INFORMANT Chester W. Haile, Jr. 1586 Harvard Rd., N. Atlanta, Ga.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decomposition 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) 15.7		INTERVAL BETWEEN ONSET AND DEATH 2004	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-22 , 1957, to 10-22 , 1957, that I last saw the deceased alive on 10-22 , 1957, and that death occurred at 10:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore 28, Md.	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		DATE SIGNED 10/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-1957	
22c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Presbyterian Cem., Sweet Air, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc.		24a. REC'D BY REGISTRAR 10/23/57	
24b. REGISTRAR'S SIGNATURE A. H. Henschel		DATE	

RECEIVED

10337

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3 Yrs 01-4			
d. NAME OF HOSPITAL (Do not in hospital give street address) OR INSTITUTION 327 Harlem Lane Caton Ridge Nursing Home				d. STREET ADDRESS 601 N. Chapelgate Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Claude A. Hammond				4. DATE OF DEATH Month Day Year Oct. 23/57 19			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH S ept. 22, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry A. Hammond				14. MOTHER'S MAIDEN NAME Mollie Swartz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Vera M. Hammond, 601 N. Chapelgate Lane			
18. CAUSE OF DEATH [Enter only one cause, or one for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis Cerebral 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) years						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 5 , 19 50 , to Oct 23 , 19 57 , that I last saw the deceased alive on 10-23- , 19 57 , and that death occurred at 8 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. J. Mendel's				ADDRESS (Street, city or town, state) DATE SIGNED 651 N Bentall St 10/24/57			
PHYSICIAN'S NAME (Type) C. J. Mendel's M.D.				Baltimore 16 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26/57		22c. NAME OF CEMETERY OR CREMATORY Louden Park		22d. LOCATION (City, town, or county) (State) Baltimore 29 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors,				24a. REC'D BY REGISTRAR DATE OCT 30 '57			
4101 Edmondson Ave. zone 29				24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

PLACE TO BE FILLED

MARYLAND

STATE OF MARYLAND, COUNTY OF BALTIMORE

DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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OCT 30 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103213

10338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b 45yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster Road				d. STREET ADDRESS Westminster Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Pinkney Last Hammond				4. DATE OF DEATH Month Oct. Day 31 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1869		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles L. Hammond				14. MOTHER'S MAIDEN NAME Catherine Hardey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Malvern G. Hammond, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Chronic decompensation DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO 5 yrs. (c) Atherosclerosis - general 5 yrs.							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓					
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) (County) (State) ✓	
21. I certify that I attended the deceased from 1-1-1957 to 11-1-1957 , that I last saw the deceased alive on 10-28-1957 , and that death occurred at 11 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 11-2-57							
ACTUAL SIGNATURE James G. Saffell		PHYSICIAN'S NAME (Type) James G. Saffell M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 11-1-57		24b. REGISTRAR'S SIGNATURE Mary B. Zline	

CERTIFICATE OF DEATH

1933

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Jan 1, 1900		Male		White		Married		Farmer		Heart Disease		Home		10:00 AM		J. Smith		A. Jones	
Place of Birth		Date of Death		Age at Death		Duration of Illness		Previous Illnesses		Manner of Death		Certified by		Registered by		Date of Registration		Signature of Registrar		Signature of Physician	
Maryland		Jan 15, 1933		33		2 weeks		None		Natural		J. Smith		A. Jones		Jan 15, 1933		A. Jones		J. Smith	

BUREAU V. 2

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10339

CERTIFICATE OF DEATH

10322 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2618 McElderry Street	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last HARMAN		4. DATE OF DEATH Month October Day 31 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/16
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY National Brewery	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry L. Harman		14. MOTHER'S MAIDEN NAME Gertrude Peterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes PL 28		16. SOCIAL SECURITY NO. 220 09 8429	
17. INFORMANT Clin. Rec. Folders. Vet. Adm. Hosp. Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28, 1957 , to October 31, 1957 , that I saw the deceased alive on October 31, 1957 , and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 10/31/57 ACTUAL SIGNATURE George Vash, M.D. PHYSICIAN'S NAME (Type) GEORGE VASH, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Phillip Herwig & Sons Funeral Home		24a. REC'D BY REGISTRAR NOV 4 1957	
24b. REGISTRAR'S SIGNATURE Denson L. Farley			

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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BUREAU V. S.

NOV 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10340

CERTIFICATE OF DEATH

10323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>				c. LENGTH OF STAY IN 1b <u>139 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>107 Albemarle Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ISAAC</u> Middle <u>E.</u> Last <u>HARRISON</u>				4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 7, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>		IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mills</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Ben Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>213-09-4210</u>		17. INFORMANT <u>Clin Rec. Vet. Adm. Hosp. Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>CARCINOMA OF LUNG</u> DUE TO (c) <u>PULMONARY TUBERCULOSIS, INACTIVE</u>						INTERVAL BETWEEN ONSET AND DEATH MINUTES <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS, INACTIVE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 14</u> , 19 <u>57</u> , to <u>October 31</u> , 19 <u>57</u> , that I saw the deceased alive on <u>June 14</u> , 19 <u>57</u> , and that death occurred at <u>7:58A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u> DATE SIGNED <u>11/1/57</u>							
ACTUAL SIGNATURE <u>Irving Freeman</u> M.D.				PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D. Chief, Medical Service</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law Mortuary, 802-04 Madison Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 6 1957</u>			
ADDRESS <u>Baltimore 1, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Lawson L. Sherry</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

NOV 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10324

10259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
c. LENGTH OF STAY IN 1b 19 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 DUNDALK 22	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 127 WILLOW SPRING RD		d. STREET ADDRESS 1127 WILLOW SPRING RD	
3. NAME OF DECEASED (Type or print) First Middle Last MATHILDA SOMMERS HARTLEY		4. DATE OF DEATH Month Day Year 10-25-1957	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 31, 1884
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME GEORGE W. SOMMERS		14. MOTHER'S MAIDEN NAME MARY SCHUEBERLEIN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. J. R. REPPES - 1304 GLENDALE BALTO 4.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED Where Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/25/57	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brock Brodley, Dundalk, Md.		24a. REC'D BY REGISTRAR OCT 29 1957	
		24b. REGISTRAR'S SIGNATURE John Kelley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE IS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

OCT 29 1957

RECEIVED

10341

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Road				d. STREET ADDRESS / Carroll Manor Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HOMER MARTIN HEACOCK				4. DATE OF DEATH Month Day Year October 25, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 30, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer- retired				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank Elbridge Heacock				14. MOTHER'S MAIDEN NAME Nary E. Werner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Katherine Klass Heacock, Baldwin, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) muscular Dystrophy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arthritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1949 1952							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1928 19 Oct 25, 1957 , that I last saw the deceased alive on Oct 25-57 , 19 9 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter M. Hammitt				ADDRESS (Street, city or town, state) Baldwin			
DATE SIGNED 10-27-57							
PHYSICIAN'S NAME (Type) Walter M. Hammitt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Trinity Episcopal Cemetery		22d. LOCATION (City, town, or county) (State) Long Green, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Soro				ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR 12-27-57	
24b. REGISTRAR'S SIGNATURE W. M. Hammitt							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		October 25, 1957		Baltimore, Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher	
Date of Birth		Place of Birth		Marital Status		Usual Residence		Signature of Physician	
January 1, 1912		Baltimore, Maryland		Married		Baltimore, Maryland		[Signature]	
Signature of Registrar		Name of Registrar		Title of Registrar		Date of Registration		Official Seal	
[Signature]		John Doe		Registrar		October 26, 1957		[Seal]	

RECEIVED
OCT 30 1957
BUREAU V.I.S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10326

10342

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		LENGTH OF STAY (in this place) 6 Wks.		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Catonsville Convalescent Home for Aged & Invalids				STREET ADDRESS 2108 Mosby Ave.,		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Pauline C. Hessler				4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 19 57.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 25, 1892	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alphonse Ricaille				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 213-36-7831		17. INFORMANT & ADDRESS Mrs. C.T. Bryant 5313 Windsor Mill Rd			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) ARTERIO SCLEROTIC CARDIAC				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) VASCULAR DISEASE - PULMONARY							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) EDEMA							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/1/55 , to 10/11/57 , that I last saw the deceased alive on 10/11/57 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
SIGNATURE John H. Strong		DATE THEREOF 10-15-1957		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR Alphonse Ricaille		25. FUNERAL DIRECTOR'S SIGNATURE John H. Strong		ADDRESS 3707 W North Ave.	
DATE OCT 15 '57							

CERTIFICATE OF DEATH

1952

State of New York

County of New York

City of New York

State of New York

City of New York

State of New York

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RECEIVED
OCT 15 1957
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10327

10343

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6yr3mths29dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm, Maryland	
3. NAME OF DECEASED (Type or print) First Max Middle E. Last Hayman		4. DATE OF DEATH Month Oct. Day 18 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Psychiatric	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 067-22-6622	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 18, 1954 , to Oct. 18, 1957 , that I last saw the deceased alive on Oct. 18, 1957 , and that death occurred at 8 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 10-18-57			
ACTUAL SIGNATURE J. Vasconcellos		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) J. VASCONCELOS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-20-57		22b. DATE THEREOF 10-20-57	
22c. NAME OF CEMETERY OR CREMATORY Beth Israel Woodbridge N.Y.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Citrus Place	
24a. REC'D BY REGISTRAR OCT 21 57		24b. REGISTRAR'S SIGNATURE Rev. Lewis	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 14 1968	
AGE		SEX	
35		Male	
RACE		EDUCATION	
White		High School	
BIRTH DATE		BIRTH PLACE	
MAY 12 1933		Memphis, Tennessee	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
Actor		Suicide	
PLACE OF DEATH		MANNER OF DEATH	
London, England		Suicide	
CITY OF DEATH		COUNTY OF DEATH	
London		Middlesex	
STATE OF DEATH		COUNTRY OF DEATH	
England		Great Britain	
DATE OF BURIAL		PLACE OF BURIAL	
MAY 15 1968		St. Martin's Church, London	
CITY OF BURIAL		COUNTY OF BURIAL	
London		Middlesex	
STATE OF BURIAL		COUNTRY OF BURIAL	
England		Great Britain	

BUREAU V. 1

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10344

CERTIFICATE OF DEATH

10328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTE.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>54</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT-Home</u>		d. STREET ADDRESS <u>1512 N. MARLYN</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK HOLZKNECHT</u>		4. DATE OF DEATH Month Day Year <u>10 - 22 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1 - 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ICE-MANUFACT</u>	
11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACOB HOLZKNECHT</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-32-2389</u>	
17. INFORMANT <u>ELFA HOLZKNECHT</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>15 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>myocardial aneurysm (left ventricle)</u>		PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 12</u> , 19 <u>42</u> to <u>Oct 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>57</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Harvey L. Fuller</u> M.D.		Ridge Rd	
PHYSICIAN'S NAME (Type) <u>Harvey L. Fuller M.D.</u>		<u>Baltimore 6 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MIRELAND PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTE. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly, Essex Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 28 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Edith Harley</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. R.

OCT 28 1957

RECEIVED

10345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swynne Oak				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1117 Baker Ave.				d. STREET ADDRESS 1902 Ridgetop Rd.			
3. NAME OF DECEASED (Type or print) First BESSIE Middle FRANCES Last HOOD				4. DATE OF DEATH Month Oct. 31, Day 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown Fleetwood				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Raymond Hood - 1917 Forest Park Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident DUE TO (c) Hypertensive Arteriosclerotic CVD						INTERVAL BETWEEN ONSET AND DEATH 5 days 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	Month. 19	Day. 19	Year. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/30 , 19 57 , to 10/31 , 19 57 , that I last saw the deceased alive on Oct 28 30 , 19 57 , and that death occurred at 5 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Kennard Goff M.D.				ADDRESS (Street, city or town, state) 3101 W Baltimore St DATE SIGNED 11/1/57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WM. J. TICKNER & SONS - B.P.B. Balto. 17, Md.				24a. REC'D BY REGISTRAR DATE 11/5/57		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

1957

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		PLACE OF BIRTH	
35		MEMPHIS, TENNESSEE	
SEX		OCCUPATION	
MALE		ATTORNEY AT LAW	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
MARRIAGE		RELIGION	
MARRIED		METHODIST	
DATE OF MARRIAGE		CAUSE OF DEATH	
JANUARY 1, 1964		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		NATURAL	
DATE OF BURIAL		PLACE OF BURIAL	
APRIL 8, 1968		MEMPHIS, TENNESSEE	
NAME OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
JAMES EARL RAY FUNERAL HOME		[Signature]	
ADDRESS OF FUNERAL HOME		DATE OF REGISTRATION	
1000 N. 3RD ST., MEMPHIS, TENN.		APRIL 10, 1968	

BUREAU V. S.

NOV 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10346
CERTIFICATE OF DEATH

10330
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. LENGTH OF STAY IN 1b <i>70yrs</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Middle River</i>		d. STREET ADDRESS <i>2215 Old Eastern Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2215 Old Eastern Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Nannie</i> Middle <i>M. Hughes</i> Last <i>Hughes</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>7</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 18, 1867</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Virginus L. Fore</i>		14. MOTHER'S MAIDEN NAME <i>Isabelle R. Frayser</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Miss Gertrude I. Hughes</i>		Address <i>2215 Old Eastern Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Ventricular fibrillation</i> DUE TO (b) <i>Coronary thrombosis</i> DUE TO (c) <i>Arteriosclerosis heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>? yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>52</i> , to <i>10/7</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>10/5</i> , 19 <i>57</i> , and that death occurred at <i>S. A. M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Platt</i>		ADDRESS (Street, city or town, state) <i>434 EASTERN Ave. East</i>	
PHYSICIAN'S NAME (Type) <i>J. PLATT, M.D.</i>		DATE SIGNED <i>10/7/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 10, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Orem's Methodist</i>		22d. LOCATION (City, town, or county) (State) <i>Stemmers Run Rd. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>		ADDRESS <i>7401 Belair Rd.</i>	
24a. REC'D BY REGISTRAR <i>DATE 10/7/57</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Shirley</i>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10347

CERTIFICATE OF DEATH

103314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 15 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. NAME OF DECEASED First OLIVER Middle --- Last IBEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3233 Ravenwood Avenue	
4. DATE OF DEATH Month October Day 23 Year 19 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Ibex		14. MOTHER'S MAIDEN NAME Addie Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 705-10-5898	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED METASTATIC LESIONS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SARCOMATOUS LESION, RIGHT KNEE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 6 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from October 8, 1957 to October 23, 1957 and that death occurred at 8:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 10/23/57 ACTUAL SIGNATURE Chien Wei Lan M.D. PHYSICIAN'S NAME (Type) CHIEN WEI LAN, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-1957	
22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Bankard and Son, Funeral Home, Westminster, Maryland		24a. REC'D BY REGISTRAR OCT 28 1957	
24b. REGISTRAR'S SIGNATURE Dawson L. Lister			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

BUREAU V. A.

OCT 28 1957

RECEIVED

10348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u>				c. LENGTH OF STAY IN 1b <u>58 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26 Spring St.</u>				d. STREET ADDRESS <u>26 Spring Street</u>			
3. NAME OF DECEASED (Type or print) <u>MARY ESTELLA Iglehart</u>				DATE OF DEATH <u>October 24, 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WEAVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WOOLEN MILL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEONIDAS Iglehart</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET E. SEVERN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Miss Edna Iglehart, Oella, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic CV disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>15 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 1957</u> to <u>October 24, 1957</u> , that I last saw the deceased alive on <u>Oct 24, 1957</u> , and that death occurred at <u>39</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. L. A. Kochman</u> M.D.				DATE SIGNED <u>October 24, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 28 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Quelch</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13 BALTIMORE - BALTIMORE STATE DEPARTMENT OF HEALTH

13 BALTIMORE - BALTIMORE STATE DEPARTMENT OF HEALTH

13 BALTIMORE - BALTIMORE STATE DEPARTMENT OF HEALTH

13 BALTIMORE - BALTIMORE STATE DEPARTMENT OF HEALTH

10349

CERTIFICATE OF DEATH

10333

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Henrietta Last Jeske				4. DATE OF DEATH Month October Day 21 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-75	
9. AGE (In years last birthday) 81? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown Hertsch				14. MOTHER'S MAIDEN NAME Louise Brunier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 26 , 19 57 , to Oct. 21 , 19 57 , that I last saw the deceased alive on Oct. 21 , 19 57 , and that death occurred at 9:55a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 10-21-57 PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schweb				ADDRESS 2101 Frederick Ave.		24a. REC'D BY REGISTRAR Oct 28 57	
24b. REGISTRAR'S SIGNATURE Oct 28 57							

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10350
CERTIFICATE OF DEATH

10334
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 20 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1412 Pennsylvania Avenue			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle E. Last JETER				4. DATE OF DEATH Month October Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/15/21	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener				10b. KIND OF BUSINESS OR INDUSTRY Real Estate Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Morgan Jeter				14. MOTHER'S MAIDEN NAME Emma Valentine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 213-16-3742		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT MIDDLE LOBE 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC ALCOHOLISM WITH FATTY LIVER 581.1 DUE TO (c) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH FEW DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 23, 1957 to October 24, 1957 and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan				DATE SIGNED 10/24/57			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.				M.D. Veterans Administration Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-28-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS		24a. REC'D BY REGISTRAR DATE Oct. 31-57	
24b. REGISTRAR'S SIGNATURE Dawson L. Farber							

CHARLES R. LAW MORTUARY, 802-04 Madison Ave. Balto., Md.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

SEX

AGE

OCCUPATION

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BUREAU V. S.

NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10351

CERTIFICATE OF DEATH

10335
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 31 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle L Last JOHNSON				4. DATE OF DEATH Month OCTOBER Day 29 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 19, 1908	
9. AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JAMES EDWARD JOHNSON			
14. MOTHER'S MAIDEN NAME ANNA SCHUDER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-11			
16. SOCIAL SECURITY NO. 216-07-1129				17. INFORMANT CLIN. REC., VET. ADMS. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from SEPTEMBER 28, 19 57 , to OCTOBER 29, 19 57 , that I lost the deceased alive on SEPTEMBER 28, 19 57 , and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10-29-57			
ACTUAL SIGNATURE _____ M.D. GEORGE VASH M.D.				PHYSICIAN'S NAME (Type) GEORGE VASH M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11/4/57			
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY				22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN A MORAN, 3000 E BALTIMORE ST BALTIMORE				24. REGISTRAR'S SIGNATURE Dr. G. L. Farber			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.

BUREAU V. S.

RECEIVED

10352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 16 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 210 BLOOMSBURY-AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First ANN Middle JOHNSON Last		4. DATE OF DEATH Oct Month 3 Day 1957 Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV-22-1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOSHUA WILLETT		14. MOTHER'S MAIDEN NAME MARGARET-ANN-WILLET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Flora E. Baker Address 210 Bloombury Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Age DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1942 to Oct 3 , 19 57 , that I last saw the deceased alive on Oct 2 , 19 57 , and that death occurred at 6 P. M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Morris B. Schreiber M.D. 54 S. Fulton Ave Baltimore		23 10 57 Md.	
PHYSICIAN'S NAME (Type) MORRIS B. SCHREIBER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct 7, 1957	Lorraine	Balto County Md
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tephel ADDRESS 5311 Edmondson Ave		24a. REC'D BY REGISTRAR OCT 7 57	24b. REGISTRAR'S SIGNATURE W. H. Schreiber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

OCT 7 1957

RECEIVED

10353

CERTIFICATE OF DEATH

Items 8, 9 Film 222 11-25-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5704 Edmondson Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sue Barger Johnson				4. DATE OF DEATH Month Day Year Oct. 18, 1957			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1891	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teller		10b. KIND OF BUSINESS OR INDUSTRY Union Trust		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest D. Hanson				14. MOTHER'S MAIDEN NAME Sue May Hurtt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-22-6417		17. INFORMANT Mr. Thomas Johnson, 5704 Edmondson Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 30 minutes 30 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 4, 1950 to Oct 12, 1957 , that I last saw the deceased alive on Oct 12, 1957 , and that death occurred at 11 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. Lassaway M.D.				ADDRESS (Street, city or town, state) 1012 1st St, Md DATE SIGNED 10/12/57			
PHYSICIAN'S NAME (Type) WILLIAM F. LASSAWAY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 21/57		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Ellicott City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR OCT 22 57		24b. REGISTRAR'S SIGNATURE Quinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10354

CERTIFICATE OF DEATH

10338

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7819 Wilson Ave.</u>				d. STREET ADDRESS <u>7819 Wilson Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>L.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7, 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US.A.</u>							
13. FATHER'S NAME <u>James Fields</u>				14. MOTHER'S MAIDEN NAME <u>Maria Hooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Naomi Jones</u> Address <u>7819 Wilson Ave. 14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Acute pulmonary edema</u>							
DUE TO (b) <u>Arteriosclerotic CVD.</u>							
DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/16</u> , 19 <u>57</u> , to <u>10/17/57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10/17/57</u> , 19 <u> </u> , and that death occurred at <u>11 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. A. Grott</u> M.D. <u>8150 Harford Rd.</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>H. A. GROTT, M.D.</u> <u>Balto 14, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>Dr. M. Bacon</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 22 OCT

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or entombment.

10355

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10339

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 32014	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Blv. Extended		d. STREET ADDRESS 2341 Madison Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CALVIN Middle Last JOY		4. DATE OF DEATH Month 10 Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Camden S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME New Gene Joy		14. MOTHER'S MAIDEN NAME Cetta Mayanna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Josephine Joy	
17. INFORMANT Josephine Joy		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 910.5 DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trench he was working in caved in	
20c. TIME OF INJURY Month, Day, Year 10-17-57		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) East. Blv.		20f. (City or town) (County) (State) Middle River Baltimore	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-57	
22c. NAME OF CEMETERY OR CREMATORY Mount Calvary		22d. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		24a. REC'D BY REGISTRAR Edith Hurley	
ADDRESS 1000 Brantley Avenue		24b. REGISTRAR'S SIGNATURE Edith Hurley	
DATE OCT 21 1957			

RECEIVED

OCT 21 1957

BUREAU V. S.

Josephine Jey
Celia Thompson
V. S. H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

10356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 602 Woodbine Terrace		d. STREET ADDRESS 602 Woodbine Terrace	
3. NAME OF DECEASED (Type or print) First JEAN Middle JOYES Last JOYES		4. DATE OF DEATH Month Oct. Day 31, Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1871
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Joyes		14. MOTHER'S MAIDEN NAME Marcella Jean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. B. Bayne Joyes - 602 Woodbine Terr. Towson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized & coronary arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 , 19 55 , to 31 , 19 57 that I last saw the deceased alive on July 31 , 19 57 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walter B. Buck M.D. 18 E. Egan St. 2 Mar 1, 57			
ACTUAL SIGNATURE WALTER B. BUCK		PHYSICIAN'S NAME (Type) WALTER B. BUCK	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/2/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickener & Sons - Balto 17, Md.		24a. REC'D BY REGISTRAR DATE 11/5/57	
24b. REGISTRAR'S SIGNATURE Markel Brays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

0753

DATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 21 1912		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
DRIVER		HEART DISEASE		NATURAL		BALTIMORE		MD		USA					
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		SECOND		DATE OF DEATH		TIME OF DEATH			
NOV 6 1957		10:30 AM		10		30		00		NOV 6 1957		10:30 AM			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS			

BUREAU V. S.

NOV 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10260

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2015 Shore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle ESTHER Last KAUFMAN		4. DATE OF DEATH Month October Day 2nd , Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 17 Hours 15 Min.	11. IF UNDER 24 HRS. Months 6 Days 17 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home (Family)	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Curry		14. MOTHER'S MAIDEN NAME Clara Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. A.W. Krieger,		Address 7450 Lawrence Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 6 WKS YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER, 1956 to 2 OCT , 19 57 , that I last saw the deceased alive on 2 OCTOBER, 1957 , and that death occurred at 8:15 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Baermann		ADDRESS (Street, city or town, state) DR. W. E. BAERMANN 33 DUNDALK AVENUE DUNDALK 22, MARYLAND	
PHYSICIAN'S NAME (Type)		DATE SIGNED Oct 7 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Bradley		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Wm. Kelly			

CERTIFICATE OF DEATH

1950

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 5, 1933		11. PLACE OF BIRTH Jackson, Mississippi		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
19. SIGNATURE OF CORONER JAMES EARL RAY		20. SIGNATURE OF JURY JAMES EARL RAY		21. SIGNATURE OF STATE ATTORNEY JAMES EARL RAY	
22. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		23. SIGNATURE OF CLERK JAMES EARL RAY		24. SIGNATURE OF REGISTRAR JAMES EARL RAY	
25. SIGNATURE OF DECEASED (None)		26. SIGNATURE OF WITNESS JAMES EARL RAY		27. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
28. SIGNATURE OF CORONER JAMES EARL RAY		29. SIGNATURE OF JURY JAMES EARL RAY		30. SIGNATURE OF STATE ATTORNEY JAMES EARL RAY	
31. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		32. SIGNATURE OF CLERK JAMES EARL RAY		33. SIGNATURE OF REGISTRAR JAMES EARL RAY	

BUREAU V. 2

OCT 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

10266 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10342
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Hospital			d. STREET ADDRESS 934 S. Kenwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANTHONY Middle F. Last KIELIAN			4. DATE OF DEATH Month 10 Day 31 Year 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 May 1923		9. AGE (In years last birthday) 34 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman "B"		10b. KIND OF BUSINESS OR INDUSTRY Steel Manuftr.		11. BIRTHPLACE (State or foreign country) Balto. Md. U.S.A.	
13. FATHER'S NAME Mr. Floryan Kielian			14. MOTHER'S MAIDEN NAME Mar yanna Szeliga		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11 217-12-3382		17. INFORMANT Mrs. Marya nna Szeliga, 934 S. Kenwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compressed fracture, posterior right parietal area. DUE TO (c) Compressed fracture, posterior, right parietal area.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work. Fell from pole at end of coal field.			
20c. TIME OF INJURY Month, Day, Year 11:50 AM 10-31-57		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) S.E. End coal field Sparrows Point 19, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M.B. Davis			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) M.B. Davis, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 5 Nov. 1957		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.
			22d. LOCATION (City, town, or county) 1300 Dundalk Ave, Balto.		(State) Balto.
23. FUNERAL DIRECTOR'S SIGNATURE Marie Fralkowski			24a. REC'D BY REGISTRAR NOV 4 1957		
			24b. REGISTRAR'S SIGNATURE Dawson L. Farley		

ARIZONA STATE DEPARTMENT OF HEALTH - TULSA
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		DATE	
JAMES E. WHITE		10-1-57	
RESIDENCE		OCCUPATION	
1234 N. GARDEN ST.		FARMER	
CITY		STATE	
TULSA		OKLAHOMA	
AGE		SEX	
45		M	
RACE		RELIGION	
WHITE		METHODIST	
EDUCATION		MARRIAGE	
HIGH SCHOOL		MARRIED	
SCHOOLING		MARRIAGE	
10-1-57		10-1-57	

RECEIVED
 NOV 4 1957
 BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
10357 Item 6 Film G222 10-29-57 et
DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10343

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr3mth18dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex, Maryland		d. STREET ADDRESS 130 Riverthorne Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Bussinuis Last Kimmel		4. DATE OF DEATH Month October Day 23 Year 19 57	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7-1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME Adolf Bussinues		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Arteriosclerotic cardiovascular disease DUE TO Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 9 , 19 57 to Oct. 23 , 19 57 , that I last saw the deceased alive on Oct. 23 , 19 57 , and that death occurred at 8:10a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 10-23-57			
ACTUAL SIGNATURE Stella Wachslar		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-57	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Balto. Md	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly Esq. - Md.		24. REC'D BY REGISTRAR DATE OCT 24 '57	
24b. REGISTRAR'S SIGNATURE W. Leach			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF BURIAL PLACE	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF CLERK		21. SIGNATURE OF CHIEF OF POLICE	
22. SIGNATURE OF SHERIFF		23. SIGNATURE OF TOWNSHIP CLERK		24. SIGNATURE OF COUNTY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF SECRETARY OF HEALTH		27. SIGNATURE OF COMMISSIONER OF HEALTH	
28. SIGNATURE OF GOVERNOR		29. SIGNATURE OF VICE GOVERNOR		30. SIGNATURE OF ATTORNEY GENERAL	
31. SIGNATURE OF JUDGE OF THE COURT OF APPEALS		32. SIGNATURE OF JUDGE OF THE CIRCUIT COURT		33. SIGNATURE OF JUDGE OF THE DISTRICT COURT	
34. SIGNATURE OF JUDGE OF THE COUNTY COURT		35. SIGNATURE OF JUDGE OF THE MOUNTAIN COURT		36. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
37. SIGNATURE OF JUDGE OF THE VILLAGE COURT		38. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		39. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
40. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		41. SIGNATURE OF JUDGE OF THE VILLAGE COURT		42. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
43. SIGNATURE OF JUDGE OF THE VILLAGE COURT		44. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		45. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
46. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		47. SIGNATURE OF JUDGE OF THE VILLAGE COURT		48. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
49. SIGNATURE OF JUDGE OF THE VILLAGE COURT		50. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		51. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
52. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		53. SIGNATURE OF JUDGE OF THE VILLAGE COURT		54. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
55. SIGNATURE OF JUDGE OF THE VILLAGE COURT		56. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		57. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
58. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		59. SIGNATURE OF JUDGE OF THE VILLAGE COURT		60. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
61. SIGNATURE OF JUDGE OF THE VILLAGE COURT		62. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		63. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
64. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		65. SIGNATURE OF JUDGE OF THE VILLAGE COURT		66. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
67. SIGNATURE OF JUDGE OF THE VILLAGE COURT		68. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		69. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
70. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		71. SIGNATURE OF JUDGE OF THE VILLAGE COURT		72. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
73. SIGNATURE OF JUDGE OF THE VILLAGE COURT		74. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		75. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
76. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		77. SIGNATURE OF JUDGE OF THE VILLAGE COURT		78. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
79. SIGNATURE OF JUDGE OF THE VILLAGE COURT		80. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		81. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
82. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		83. SIGNATURE OF JUDGE OF THE VILLAGE COURT		84. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
85. SIGNATURE OF JUDGE OF THE VILLAGE COURT		86. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		87. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
88. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		89. SIGNATURE OF JUDGE OF THE VILLAGE COURT		90. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
91. SIGNATURE OF JUDGE OF THE VILLAGE COURT		92. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		93. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
94. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		95. SIGNATURE OF JUDGE OF THE VILLAGE COURT		96. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	
97. SIGNATURE OF JUDGE OF THE VILLAGE COURT		98. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		99. SIGNATURE OF JUDGE OF THE VILLAGE COURT	
100. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT		101. SIGNATURE OF JUDGE OF THE VILLAGE COURT		102. SIGNATURE OF JUDGE OF THE TOWNSHIP COURT	

RECEIVED
OCT 24 1957
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10358

CERTIFICATE OF DEATH

10344 44

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 37 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2023 Ramsay Street	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle W. Last KOEHLER		4. DATE OF DEATH Month October Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/96
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Power Station Operator		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Koehler		14. MOTHER'S MAIDEN NAME Margaret Hoffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 220-03-9283	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADENOCARCINOMA SIGMOID DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 2 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from August 29 , 19 57 , to October 5 , 19 57 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 10/6/57			
ACTUAL SIGNATURE E. H. WILSON, M. D.		PHYSICIAN'S NAME (Type) Fort Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF OCT. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab		24a. REC'D BY REGISTRAR 1957	
24b. REGISTRAR'S SIGNATURE Danson L. Farley			

VS A15 (4)
15M 9/55

GEORGE L. SCHWAB 2101 Frederick Ave, Balto., Md.

CERTIFICATE OF DEATH

Page No. 10

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		5-1-28		MOBILE, ALABAMA	
SEX		AGE		OCCUPATION	
Male		37 years		None	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
None		6-4-68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
Heart Disease		Natural		None	
DISEASE OR INJURY		TIME OF DEATH		DATE OF INTERMENT	
Myocardial Infarction		10:15 AM		None	
MEDICAL HISTORY		DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN	
None		None		None	
HISTORY OF PRESENT ILLNESS		DATE OF ADMISSION TO HOSPITAL		NAME OF HOSPITAL	
None		None		None	
TREATMENT		DATE OF DISCHARGE		NAME OF PHYSICIAN	
None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
None		None		None	
SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
None		None		None	

BUREAU V. S.

1001 8 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

Items 18-21 Film 221 10-17-57 ams See: Item 17, et										10359										Certificate of Death										1034533									
Reg. Dist. No.																																							
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wing Mills.</u>										c. LENGTH OF STAY IN 1b <u>95 yrs.</u>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14441N981M1N Baltimore 13 3 Vol-4</u>																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD State Training School</u>										d. STREET ADDRESS <u>3200 Clarence Avenue</u>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>John</u> Last <u>Kohl Jr.</u>										4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1957-</u>																													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/137</u>				9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.																									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>										10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>										11. BIRTHPLACE (State or foreign country) <u>MD, Baltimore</u>										12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>									
13. FATHER'S NAME <u>Robert J. Kohl Sr.</u>										14. MOTHER'S MAIDEN NAME <u>Flora Kraus Kohl-</u>																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>										16. SOCIAL SECURITY NO. (If yes, give war or dates of service)										17. INFORMANT Address <u>Parents, 3200 Clarence Ave. - Zone 13</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>500X</u> DUE TO <u>Broncho-pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>491X</u> DUE TO (b) <u>Acute Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spastic diplegic (Idiot), Hypo-pituitarism or primary gonadal defect, cardiac anomaly of undetermined type</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>14/12/1957</u> <u>2 days</u>																																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Oct 12</u> , 19 <u>57</u> , to <u>Oct 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 12</u> , 19 <u>57</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. <u>Harry G. Butler, M.D.</u> ADDRESS (Street, city or town, state) <u>Rosewood State Training School</u> DATE SIGNED <u>Oct 15 1957</u> ACTUAL SIGNATURE <u>CONRADO Bugert MD.</u> M.D. <u>Rosewood State Training School</u> PHYSICIAN'S NAME (Type) <u>CONRADO Bugert MD.</u>																																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>10/15/57</u>										22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>										22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, 3331 Brehms Lane</u>										ADDRESS <u>3331 Brehms Lane</u>										24a. REC'D BY REGISTRAR <u>DATE 15 1957</u>										24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>									

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form 10-1-57

1. NAME OF DECEASED WILLIAM J. BROWN		2. SEX MALE	
3. DATE OF BIRTH 1915		4. PLACE OF BIRTH NEW YORK	
5. DATE OF DEATH 1957		6. PLACE OF DEATH NEW YORK	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. SIGNATURE OF DECEASED WILLIAM J. BROWN		10. SIGNATURE OF WITNESS JOHN D. SMITH	
11. SIGNATURE OF DECEASED WILLIAM J. BROWN		12. SIGNATURE OF WITNESS JOHN D. SMITH	
13. SIGNATURE OF DECEASED WILLIAM J. BROWN		14. SIGNATURE OF WITNESS JOHN D. SMITH	
15. SIGNATURE OF DECEASED WILLIAM J. BROWN		16. SIGNATURE OF WITNESS JOHN D. SMITH	
17. SIGNATURE OF DECEASED WILLIAM J. BROWN		18. SIGNATURE OF WITNESS JOHN D. SMITH	
19. SIGNATURE OF DECEASED WILLIAM J. BROWN		20. SIGNATURE OF WITNESS JOHN D. SMITH	
21. SIGNATURE OF DECEASED WILLIAM J. BROWN		22. SIGNATURE OF WITNESS JOHN D. SMITH	
23. SIGNATURE OF DECEASED WILLIAM J. BROWN		24. SIGNATURE OF WITNESS JOHN D. SMITH	
25. SIGNATURE OF DECEASED WILLIAM J. BROWN		26. SIGNATURE OF WITNESS JOHN D. SMITH	
27. SIGNATURE OF DECEASED WILLIAM J. BROWN		28. SIGNATURE OF WITNESS JOHN D. SMITH	
29. SIGNATURE OF DECEASED WILLIAM J. BROWN		30. SIGNATURE OF WITNESS JOHN D. SMITH	
31. SIGNATURE OF DECEASED WILLIAM J. BROWN		32. SIGNATURE OF WITNESS JOHN D. SMITH	
33. SIGNATURE OF DECEASED WILLIAM J. BROWN		34. SIGNATURE OF WITNESS JOHN D. SMITH	
35. SIGNATURE OF DECEASED WILLIAM J. BROWN		36. SIGNATURE OF WITNESS JOHN D. SMITH	
37. SIGNATURE OF DECEASED WILLIAM J. BROWN		38. SIGNATURE OF WITNESS JOHN D. SMITH	
39. SIGNATURE OF DECEASED WILLIAM J. BROWN		40. SIGNATURE OF WITNESS JOHN D. SMITH	
41. SIGNATURE OF DECEASED WILLIAM J. BROWN		42. SIGNATURE OF WITNESS JOHN D. SMITH	
43. SIGNATURE OF DECEASED WILLIAM J. BROWN		44. SIGNATURE OF WITNESS JOHN D. SMITH	
45. SIGNATURE OF DECEASED WILLIAM J. BROWN		46. SIGNATURE OF WITNESS JOHN D. SMITH	
47. SIGNATURE OF DECEASED WILLIAM J. BROWN		48. SIGNATURE OF WITNESS JOHN D. SMITH	
49. SIGNATURE OF DECEASED WILLIAM J. BROWN		50. SIGNATURE OF WITNESS JOHN D. SMITH	
51. SIGNATURE OF DECEASED WILLIAM J. BROWN		52. SIGNATURE OF WITNESS JOHN D. SMITH	
53. SIGNATURE OF DECEASED WILLIAM J. BROWN		54. SIGNATURE OF WITNESS JOHN D. SMITH	
55. SIGNATURE OF DECEASED WILLIAM J. BROWN		56. SIGNATURE OF WITNESS JOHN D. SMITH	
57. SIGNATURE OF DECEASED WILLIAM J. BROWN		58. SIGNATURE OF WITNESS JOHN D. SMITH	
59. SIGNATURE OF DECEASED WILLIAM J. BROWN		60. SIGNATURE OF WITNESS JOHN D. SMITH	
61. SIGNATURE OF DECEASED WILLIAM J. BROWN		62. SIGNATURE OF WITNESS JOHN D. SMITH	
63. SIGNATURE OF DECEASED WILLIAM J. BROWN		64. SIGNATURE OF WITNESS JOHN D. SMITH	
65. SIGNATURE OF DECEASED WILLIAM J. BROWN		66. SIGNATURE OF WITNESS JOHN D. SMITH	
67. SIGNATURE OF DECEASED WILLIAM J. BROWN		68. SIGNATURE OF WITNESS JOHN D. SMITH	
69. SIGNATURE OF DECEASED WILLIAM J. BROWN		70. SIGNATURE OF WITNESS JOHN D. SMITH	
71. SIGNATURE OF DECEASED WILLIAM J. BROWN		72. SIGNATURE OF WITNESS JOHN D. SMITH	
73. SIGNATURE OF DECEASED WILLIAM J. BROWN		74. SIGNATURE OF WITNESS JOHN D. SMITH	
75. SIGNATURE OF DECEASED WILLIAM J. BROWN		76. SIGNATURE OF WITNESS JOHN D. SMITH	
77. SIGNATURE OF DECEASED WILLIAM J. BROWN		78. SIGNATURE OF WITNESS JOHN D. SMITH	
79. SIGNATURE OF DECEASED WILLIAM J. BROWN		80. SIGNATURE OF WITNESS JOHN D. SMITH	
81. SIGNATURE OF DECEASED WILLIAM J. BROWN		82. SIGNATURE OF WITNESS JOHN D. SMITH	
83. SIGNATURE OF DECEASED WILLIAM J. BROWN		84. SIGNATURE OF WITNESS JOHN D. SMITH	
85. SIGNATURE OF DECEASED WILLIAM J. BROWN		86. SIGNATURE OF WITNESS JOHN D. SMITH	
87. SIGNATURE OF DECEASED WILLIAM J. BROWN		88. SIGNATURE OF WITNESS JOHN D. SMITH	
89. SIGNATURE OF DECEASED WILLIAM J. BROWN		90. SIGNATURE OF WITNESS JOHN D. SMITH	
91. SIGNATURE OF DECEASED WILLIAM J. BROWN		92. SIGNATURE OF WITNESS JOHN D. SMITH	
93. SIGNATURE OF DECEASED WILLIAM J. BROWN		94. SIGNATURE OF WITNESS JOHN D. SMITH	
95. SIGNATURE OF DECEASED WILLIAM J. BROWN		96. SIGNATURE OF WITNESS JOHN D. SMITH	
97. SIGNATURE OF DECEASED WILLIAM J. BROWN		98. SIGNATURE OF WITNESS JOHN D. SMITH	
99. SIGNATURE OF DECEASED WILLIAM J. BROWN		100. SIGNATURE OF WITNESS JOHN D. SMITH	

BUREAU V. 2

OCT 15 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the date prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10360

CERTIFICATE OF DEATH

10346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,				c. LENGTH OF STAY IN 1b 38 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 622 West Thirty-third Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK		First		Middle H.		Last KONE	
4. DATE OF DEATH October		Month		Day 17		Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 20, 1899	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank H. Kone				14. MOTHER'S MAIDEN NAME Sara Schaffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 717-07-8817		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF LIVER* - DURATION UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from September 9, 1957 , to October 17, 1957 . Irving Freeman saw the deceased alive on September 9, 1957 and that death occurred at 8:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 10/18/57 PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-57		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenoweth, Jr.				ADDRESS 3615-17 Chestnut Ave.		24a. REC'D BY REGISTRAR DATE 10/21/57	
				24b. REGISTRAR'S SIGNATURE Sawson L. Parkey			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU V. S.

OCT 22 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10361

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 211 South Pulaski Street	
3. NAME OF DECEASED (Type or print) First EDWARD Middle H. Last KRATZ		4. DATE OF DEATH Month October Day 22 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1915
9. AGE (In years last birthday) yrs. 42		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driller		10b. KIND OF BUSINESS OR INDUSTRY Concrete Company	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Kratz		14. MOTHER'S MAIDEN NAME Wilhelmina Bucktold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 215-05-3789	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CIRRHOSIS OF LIVER DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12:30 PM		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 21, 19 57 to October 22, 19 57 , and that death occurred at 6:50 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED CHHEN WEI LAN, M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 10/23/57			
ACTUAL SIGNATURE Chien Wei Lan			
PHYSICIAN'S NAME (Type) CHHEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Schwab		24a. REC'D BY REGISTRAR DATE OCT 25 1957	
24b. REGISTRAR'S SIGNATURE Rawson L. Farley		24c. REGISTRAR'S SIGNATURE	

10362

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills P.O.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills P.O.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wards Chapel Rd.				d. STREET ADDRESS Wards Chapel Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILHELMINA Middle ELIZABETH Last KUHN				4. DATE OF DEATH Month Oct. Day 7 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis Bachmann				14. MOTHER'S MAIDEN NAME Elisa Kern			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. K. Elise Fitzpatrick - Ward Chapel Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29 , 19 54 , to 10-7-57 , 19 57 , that I last saw the deceased alive on 9-24 , 19 57 , and that death occurred at 11: A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Martin E. Strobel M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D. Reisterstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Linkner & Sons - Reisterstown				24a. REC'D BY REGISTRAR OCT 8 1957		24b. REGISTRAR'S SIGNATURE Mary Elise	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
OCT 9 1957
BUREAU V. S.

10363 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 4Yrs. 4Mos. 23Das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Sheppard and Enoch Pratt Hospital				d. STREET ADDRESS 1529 Linden Avenue			
3. NAME OF DECEASED (Type or print) First William Middle Kurrelmeyer Last Kurrelmeyer				4. DATE OF DEATH Month October Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Eberhard Kurrelmeyer				14. MOTHER'S MAIDEN NAME Bernadine Veditz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 da 4 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Brain Syndrome due to Arteriosclerosis.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16, 1953 to Oct 9, 1957 , that I last saw the deceased alive on Oct 8, 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William W. Elgin M.D.				ADDRESS (Street, city or town, state) Sheppard Pratt Hosp. Towson, Md.			
PHYSICIAN'S NAME (Type) William W. Elgin, M.D.				DATE SIGNED Oct 9, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons				ADDRESS 1900 Eutaw Place			
24a. REC'D BY REGISTRAR DATE				24b. REGISTRAR'S SIGNATURE MAKEL GRAY			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Birth		Cause of Death	
John Doe		45		Male		White		1912		1957		New York		Heart Disease	
Residence		Occupation		Marital Status		Education		Religion		Burial Place		Burial Date		Burial Time	
1234 Main St		Teacher		Married		High School		Catholic		St. Mary's		1957		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Home		Signature of Burial Society		Signature of Cemetery		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU Y. S.

OCT 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10267 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford Balto MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Relay					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1701 River Road				d. STREET ADDRESS 1701 River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Paul Leroy Lanahan				4. DATE OF DEATH Month Day Year Oct, 29, 1957 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29, 1918 Oct. 28, 1918			
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridgman				10b. KIND OF BUSINESS OR INDUSTRY Const. Work		11. BIRTHPLACE (State or foreign country) Md			
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216,032372		17. INFORMANT Maudie Lanahan Address 1701 River Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Geo. S. M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Oct. 29, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/1/57		22c. NAME OF CEMETERY OR CREMATORY Medowridge		22d. LOCATION (City, town, or county) (State) Dorsey Anne Brundel, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph T. Ambrose 1328 Sulphur Sp				24a. REC'D BY REGISTRAR NOV 4 1957		24b. REGISTRAR'S SIGNATURE Dr. Geo. S. M. Kieffer			

MAINTAIN STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 4 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10364

CERTIFICATE OF DEATH

Reg. Dist. No. 10351

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home-N. Rolling Rd				d. STREET ADDRESS 201 N. Rolling Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NETTIE Middle L. Last LENHARD				4. DATE OF DEATH Month Oct. Day 3 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1890		9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Treas.		10b. KIND OF BUSINESS OR INDUSTRY Retail Shoes		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Wm. Lenhard				14. MOTHER'S MAIDEN NAME Mary Louise Pruett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. R. E. Lenhard - 217 St. Dunstons Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arterio-sclerosis							INTERVAL BETWEEN ONSET AND DEATH 10 Min years 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcified fibroid							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from March, 1939 to Oct 3, 1957 , that I last saw the deceased alive on Oct 1, 1957 , and that death occurred at 9:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. J. Lickner				ADDRESS (Street, city or town, state) 1118 St. Paul St. DATE SIGNED			
PHYSICIAN'S NAME (Type) Wetherbee Fort, M. D., 1118 St. Paul Street, Baltimore, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/7/57	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Com.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner				24a. REC'D BY REGISTRAR DATE OCT 8		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10366

CERTIFICATE OF DEATH

10353 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIE Middle (NMI) Last LEWIS				4. DATE OF DEATH Month October Day 5 Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/94	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood House		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Spencer Lewis				14. MOTHER'S MAIDEN NAME Susan (Maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 218-01-9007		17. INFORMANT Clin. Recs. Vets. Admin. Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1. CARCINOMA OF PROSTATE WITH REGIONAL METASTASIS AND 177x 2. OBSTRUCTION URETIS, HYDRONEPHROSIS, BILATERAL, ABSCESS 3. GENERALIZED PERITONITIS DUE TO ALGERATION OF SMALL INTESTINE Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. UNKNOWN OF KIDNEY DUE TO NUMBER 1 ABOVE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that VA attended the deceased from September 9 , 19 57 , to October 5 , 19 57 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 10/5/57							
ACTUAL SIGNATURE Chien Wei Lan		M.D. Veterans Administration Hospital					
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.		Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/9/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson		ADDRESS 1000 Brantley Ave.		24a. REC'D BY REGISTRAR 10/8 1957	24b. REGISTRAR'S SIGNATURE Lawson L. Harber		

Elroy Wilson Funeral Home, 2004 Orleans St, Balto., Md.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		1957	
Age		Sex	
65		Male	
Place of Birth		Cause of Death	
New York City		Heart Disease	
Date of Burial		Place of Burial	
1957		Catholic Cemetery	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 8

OCT 9 1957

RECEIVED

10365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 Stanley Dr.</u>				d. STREET ADDRESS <u>8 Stanley Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARIE E. LEWIS</u>				4. DATE OF DEATH <u>10/17</u> 19 <u>57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/85</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Phillip Brendel</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Wachter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(same)</u>			
17. INFORMANT <u>Catherine Hartoff</u>				Address <u>(same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>ASCVD -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u> (b) <u>ASCVD -</u> DUE TO <u>3 yrs</u> (c) <u>Immed.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal Mass - Ca of Large Bowel</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/12, 1955</u> to <u>10/17, 1957</u> that I last saw the deceased alive on <u>10/17, 1957</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor A. Zing</u>				ADDRESS (Street, city or town, state) <u>Catonsville, Md</u>			
DATE SIGNED <u>10/18/57</u>							
PHYSICIAN'S NAME (Type) <u>Marshall & Don</u>				ADDRESS <u>28</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUNDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall & Don</u>				24a. REC'D. BY REGISTRAR DATE <u>OCT 23 57</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrlmth18dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. 3401-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1400 Cooksie Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Viola Middle Last Lorenz				4. DATE OF DEATH Month October Day 11 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1915 unknown	9. AGE (In years last birthday) 42 257 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Lorenz				14. MOTHER'S MAIDEN NAME Annie Lorenz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.7 DUE TO Subdural hemorrhage due to accident Conditions, if any, which gave rise to immediate cause (b) Contusion due to fall (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) now known					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove State Hosp. Catonsville		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo M. Kieffer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/13/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. ...				24a. REC'D BY REGISTRAR 10/17/57		24b. REGISTRAR'S SIGNATURE H. Hedrick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARKANSAS STATE DEPARTMENT OF HEALTH - INDIANAPOLIS 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The text is mostly illegible due to fading and bleed-through.

BUREAU V. 8

OCT 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reburial.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10368

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 9 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Seton Institute / Baltimore 3 VOI-4	d. STREET ADDRESS 826 S. Ellwood Avenue /Seton Institute
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ann Middle Catherine Last Lynch		4. DATE OF DEATH Month October Day 28 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookfolder		10b. KIND OF BUSINESS OR INDUSTRY Bookstore	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Dennis Lynch		14. MOTHER'S MAIDEN NAME Ann Tewey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary vascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) fracture left hip due to a fall			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.) Fell on way to lavatory sustaining a fractured left hip	
20c. TIME OF INJURY Month, Day, Year 10-16 19 57 Hour 11:45 PM		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 10-29-57	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/30/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		ADDRESS 3000 E. Balto. St.	
24a. REC'D BY REGISTRAR NOV 1 '57		24b. REGISTRAR'S SIGNATURE Albert Seuch	

STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

RECEIVED

10369

CERTIFICATE OF DEATH

10356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write CATONSVILLE) RURAL and give nearest town				c. CITY OR TOWN (If outside corporate limits, write RURAL - ANNAPOLIS, MD. 02X2.2)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 SPRING GROVE STATE HOSP.				d. STREET ADDRESS 39 MURRAY AV.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FENWICK Middle L Last LYONS				4. DATE OF DEATH Month 10 Day 26 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-89		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY at State Hospital		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM F. LYONS				14. MOTHER'S MAIDEN NAME SALLIE OLIVER LEATHERBURY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address MRS. EARNEST HAWKINS 4 STEELE AV. ANNAPOLIS MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enterocolitis (undetermined cause) 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 9/16/57 , 19 57 , to 10/26/57 , 19 57 , that I last saw the deceased alive on 10/26/57 , 19 57 , and that death occurred at 8:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED							
ACTUAL SIGNATURE C. Eugene Waterman M.D. Spring Grove State Hospital							
PHYSICIAN'S NAME (Type) c. Eugene Waterman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF OCT 29 1957	22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM.		22d. LOCATION (City, town, or county) ANNAPOLIS MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR - SONS				ADDRESS ANNAPOLIS MD		24a. REC'D BY REGISTRAR DATE 10/28/57	
				24b. REGISTRAR'S SIGNATURE W. H. Leach			

OCT 30 '57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DEPARTMENT

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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BUREAU V. 1

OCT 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10357

10268

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands				c. LENGTH OF STAY IN 1b 12 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2904 Ohio Ave.				d. STREET ADDRESS 2904 Ohio Ave.			
3. NAME OF DECEASED (Type or print) First Alva Middle L. Last Manser				4. DATE OF DEATH Month Oct. Day 3, Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1905	
9. AGE (In years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Arthur Trimper				14. MOTHER'S MAIDEN NAME Ada Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Frederick H. Manser Address 2904 Ohio Ave., (27)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER of COLON DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore, (County) (State)							
21. I certify that I attended the deceased from July 4, 1947 to Oct 3, 1957 that I last saw the deceased alive on Oct 2, 1957 and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1074/57 DATE SIGNED 10/4/57							
ACTUAL SIGNATURE Paul Schinfeld M.D.							
PHYSICIAN'S NAME (Type) Dr Paul Schinfeld							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong ADDRESS 3207 W. North Ave				24a. REC'D BY REGISTRAR OCT 7 1957		24b. REGISTRAR'S SIGNATURE Geo M. Jeffrey	

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 7 1957

RECEIVED

10269

CERTIFICATE OF DEATH

10358

Reg. Dist. No.

42

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. LENGTH OF STAY IN 1b 16 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1210 Francis Ave.				d. STREET ADDRESS 1210 Francis Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Angelo C. Marguglio				4. DATE OF DEATH Month Day Year October 15, 1957 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Demonic Marguglio				14. MOTHER'S MAIDEN NAME Rose Fiore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 065-12-2688		17. INFORMANT Mary Marguglio 1210 Francis Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease 5 yrs (c) Arteriosclerotic Heart Disease Undet. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chr. Myocarditis							
INTERVAL BETWEEN ONSET AND DEATH 6 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 10 , 19 57 , to Oct 15 , 19 57 , that I last saw the deceased alive on Oct 15 , 19 57 , and that death occurred at 8:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE AB Daughasthy				DATE SIGNED 10-16-57			
PHYSICIAN'S NAME (Type) Dr. M. T. Tupper							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Dorsey Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrase Inc 1328 Sulphur Sp. Rd.				24a. REC'D BY REGISTRAR OCT 18 1957			
24b. REGISTRAR'S SIGNATURE Dr. M. T. Tupper							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Baltimore

Maryland

in the City of Baltimore

1210 Francis Ave.

1210 Francis Ave.

Angelo C. Marzullo

October 1, 1957

January 1, 1958

Male

Busconer

Self employed

Self

Domestic Partnership

Rose Marie

665-15-008 Mary Marzullo 1210 Francis Ave.

BUREAU Y. I.

OCT 18 1957

RECEIVED

OCT 18 1957

Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10370

CERTIFICATE OF DEATH

1035944
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 734 W. Bradley St.			
3. NAME OF DECEASED (Type or print) GEORGE (Also WILLIAM) W. MASSENBURG				4. DATE OF DEATH October 24 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 12, 1896	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper				10b. KIND OF BUSINESS OR INDUSTRY Restuarant		11. BIRTHPLACE (State or foreign country) Emporia, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ed Massenburg				14. MOTHER'S MAIDEN NAME Sally Weaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 239-32-7999			
17. INFORMANT Clin. Red., Vet. Adm. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE, 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 2 months.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 57 Hour a. m. VA p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 22, 19 57, to October 24, 19 57 , that the deceased died on October 24, 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5501 Frederick Ave., Balto., Md. DATE SIGNED 10/26/57							
ACTUAL SIGNATURE Irving L. Shmberg M.D.				PHYSICIAN'S NAME (Type) Irving L. Shmberg M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-29-57				22b. DATE THEREOF 10-29-57			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave., Balto., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802 Madison Ave.			
24a. REC'D BY REGISTRAR Oct 31				24b. REGISTRAR'S SIGNATURE Dawson L. Farby			

Charles R. Law, 802 Madison Ave., Baltimore, Md.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
1957
CERTIFICATE OF DEATH

11-570

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Time of death: [illegible]
8. Cause of death: [illegible]
9. Place of death: [illegible]
10. Signature of attending physician: [illegible]
11. Signature of registrar: [illegible]
12. Date of registration: [illegible]

BUREAU V. S.

NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10360

10371 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>			c. LENGTH OF STAY IN TB <u>35</u> yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>606 Milford Rd.</u>				d. STREET ADDRESS <u>606 Milford Mill Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>LEE</u> Last <u>MATHER</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>19</u> , Year <u>19 57</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-21-1892</u>		9. AGE (In years last birthday) <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Caltrider</u>				14. MOTHER'S MAIDEN NAME <u>Florence Ford</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Richard Mather, 606 Milford Rd., Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> (c) <u>Arterio sclerosis</u> 15 year								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1951</u> , to <u>1957</u> , that I last saw the deceased alive on <u>10/17</u> , 19 <u>57</u> , and that death occurred at <u>1A</u> M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Louis Dalmau</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>LOUIS DALMAU</u>				<u>Pikesville 8, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Frank H. Newell - Pikesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>			

CERTIFICATE OF DEATH

1957

Form 100-104

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. MARITAL STATUS [REDACTED]		7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MEDICAL HISTORY [REDACTED]		10. PRESENT ILLNESS [REDACTED]		11. DATE OF DEATH [REDACTED]		12. PLACE OF DEATH [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]		19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]		23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]		27. SIGNATURE OF DECEASED [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]		31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]		35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]		39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]		43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]	
45. SIGNATURE OF DECEASED [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]		47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]		51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]		55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]	
57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF WITNESS [REDACTED]		59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]		63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]		67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]	
69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]		71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]		75. SIGNATURE OF DECEASED [REDACTED]		76. SIGNATURE OF WITNESS [REDACTED]	
77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]		79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]		83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]		87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF WITNESS [REDACTED]	
89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]		91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]		95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. 3

OCT 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 66 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Baltimore				d. STREET ADDRESS 1504 Matthew Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle L. Last MATTHEU				4. DATE OF DEATH Month October Day 10 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1897	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crater		10b. KIND OF BUSINESS OR INDUSTRY Air Craft Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Mattheu				14. MOTHER'S MAIDEN NAME Frances Homolka			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-05-7824		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA, RIGHT LUNG WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis, cervical spine. Operation- Pneumonectomy - October 1956						INTERVAL BETWEEN ONSET AND DEATH 12 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. VA	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA	(County) (State)
21. I certify that I attended the deceased from August 5, 1957 , to October 10, 1957 , and that death occurred at 1:15 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/10/57							
ACTUAL SIGNATURE Irving Freeman M.D.				PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 12 - 57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Eastern Avenue, Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. G. Connelly & Sons, 418 Eastern Ave. Baltimore, Md.				24a. REC'D BY REGISTRAR 10/11/57			
				24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

RECEIVED

OCT 14 1957

BUREAU A. R.

1. NAME OF DEATH		2. SEX		3. AGE		4. RACE		5. RELIGION		6. OCCUPATION		7. MARITAL STATUS		8. PLACE OF BIRTH		9. DATE OF BIRTH		10. DATE OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF DEATH		15. SIGNATURE OF WITNESS		16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF CORONER		21. SIGNATURE OF JURY		22. SIGNATURE OF COURT		23. SIGNATURE OF STATE		24. SIGNATURE OF UNION		25. SIGNATURE OF COUNTY		26. SIGNATURE OF CITY		27. SIGNATURE OF TOWN		28. SIGNATURE OF VILLAGE		29. SIGNATURE OF HAMLET		30. SIGNATURE OF COUNTRY		31. SIGNATURE OF WORLD		32. SIGNATURE OF UNIVERSE		33. SIGNATURE OF GOD		34. SIGNATURE OF DEVIL		35. SIGNATURE OF ANGEL		36. SIGNATURE OF DEMON		37. SIGNATURE OF SPIRIT		38. SIGNATURE OF GHOST		39. SIGNATURE OF PHANTOM		40. SIGNATURE OF SPECTER		41. SIGNATURE OF GHOSTLY		42. SIGNATURE OF SPIRITUAL		43. SIGNATURE OF METAPHYSICAL		44. SIGNATURE OF SUPERNATURAL		45. SIGNATURE OF MIRACULOUS		46. SIGNATURE OF DIVINE		47. SIGNATURE OF SACRED		48. SIGNATURE OF HOLY		49. SIGNATURE OF BLESSED		50. SIGNATURE OF BEATIFIED		51. SIGNATURE OF CANONIZED		52. SIGNATURE OF SAINT		53. SIGNATURE OF MARTYR		54. SIGNATURE OF CONFESSOR		55. SIGNATURE OF VIRGIN		56. SIGNATURE OF MONK		57. SIGNATURE OF NUN		58. SIGNATURE OF PRIEST		59. SIGNATURE OF BISHOP		60. SIGNATURE OF CARDINAL		61. SIGNATURE OF POPE		62. SIGNATURE OF KING		63. SIGNATURE OF QUEEN		64. SIGNATURE OF EMPEROR		65. SIGNATURE OF EMPRESS		66. SIGNATURE OF CAESAR		67. SIGNATURE OF CONQUEROR		68. SIGNATURE OF RULER		69. SIGNATURE OF LORD		70. SIGNATURE OF MASTER		71. SIGNATURE OF OWNER		72. SIGNATURE OF PROPRIETOR		73. SIGNATURE OF MANAGER		74. SIGNATURE OF SUPERVISOR		75. SIGNATURE OF DIRECTOR		76. SIGNATURE OF PRESIDENT		77. SIGNATURE OF VICE PRESIDENT		78. SIGNATURE OF CHAIRMAN		79. SIGNATURE OF MEMBER		80. SIGNATURE OF REPRESENTATIVE		81. SIGNATURE OF DELEGATE		82. SIGNATURE OF ATTORNEY		83. SIGNATURE OF LAWYER		84. SIGNATURE OF JUDGE		85. SIGNATURE OF CLERK		86. SIGNATURE OF SHERIFF		87. SIGNATURE OF CORONER		88. SIGNATURE OF JURY		89. SIGNATURE OF COURT		90. SIGNATURE OF STATE		91. SIGNATURE OF UNION		92. SIGNATURE OF COUNTY		93. SIGNATURE OF CITY		94. SIGNATURE OF TOWN		95. SIGNATURE OF VILLAGE		96. SIGNATURE OF HAMLET		97. SIGNATURE OF COUNTRY		98. SIGNATURE OF WORLD		99. SIGNATURE OF UNIVERSE		100. SIGNATURE OF GOD		101. SIGNATURE OF DEVIL		102. SIGNATURE OF ANGEL		103. SIGNATURE OF DEMON		104. SIGNATURE OF SPIRIT		105. SIGNATURE OF GHOST		106. SIGNATURE OF PHANTOM		107. SIGNATURE OF SPECTER		108. SIGNATURE OF GHOSTLY		109. SIGNATURE OF SPIRITUAL		110. SIGNATURE OF METAPHYSICAL		111. SIGNATURE OF SUPERNATURAL		112. SIGNATURE OF MIRACULOUS		113. SIGNATURE OF DIVINE		114. SIGNATURE OF SACRED		115. SIGNATURE OF HOLY		116. SIGNATURE OF BLESSED		117. SIGNATURE OF BEATIFIED		118. SIGNATURE OF CANONIZED		119. SIGNATURE OF SAINT		120. SIGNATURE OF MARTYR		121. SIGNATURE OF CONFESSOR		122. SIGNATURE OF VIRGIN		123. SIGNATURE OF MONK		124. SIGNATURE OF NUN		125. SIGNATURE OF PRIEST		126. SIGNATURE OF BISHOP		127. SIGNATURE OF CARDINAL		128. SIGNATURE OF POPE		129. SIGNATURE OF KING		130. SIGNATURE OF QUEEN		131. SIGNATURE OF EMPEROR		132. SIGNATURE OF EMPRESS		133. SIGNATURE OF CAESAR		134. SIGNATURE OF CONQUEROR		135. SIGNATURE OF RULER		136. SIGNATURE OF LORD		137. SIGNATURE OF MASTER		138. SIGNATURE OF OWNER		139. SIGNATURE OF PROPRIETOR		140. SIGNATURE OF MANAGER		141. SIGNATURE OF SUPERVISOR		142. SIGNATURE OF DIRECTOR		143. SIGNATURE OF PRESIDENT		144. SIGNATURE OF VICE PRESIDENT		145. SIGNATURE OF CHAIRMAN		146. SIGNATURE OF MEMBER		147. SIGNATURE OF REPRESENTATIVE		148. SIGNATURE OF DELEGATE		149. SIGNATURE OF ATTORNEY		150. SIGNATURE OF LAWYER		151. SIGNATURE OF JUDGE		152. SIGNATURE OF CLERK		153. SIGNATURE OF SHERIFF		154. SIGNATURE OF CORONER		155. SIGNATURE OF JURY		156. SIGNATURE OF COURT		157. SIGNATURE OF STATE		158. SIGNATURE OF UNION		159. SIGNATURE OF COUNTY		160. SIGNATURE OF CITY		161. SIGNATURE OF TOWN		162. SIGNATURE OF VILLAGE		163. SIGNATURE OF HAMLET		164. SIGNATURE OF COUNTRY		165. SIGNATURE OF WORLD		166. SIGNATURE OF UNIVERSE		167. SIGNATURE OF GOD		168. SIGNATURE OF DEVIL		169. SIGNATURE OF ANGEL		170. SIGNATURE OF DEMON		171. SIGNATURE OF SPIRIT		172. SIGNATURE OF GHOST		173. SIGNATURE OF PHANTOM		174. SIGNATURE OF SPECTER		175. SIGNATURE OF GHOSTLY		176. SIGNATURE OF SPIRITUAL		177. SIGNATURE OF METAPHYSICAL		178. SIGNATURE OF SUPERNATURAL		179. SIGNATURE OF MIRACULOUS		180. SIGNATURE OF DIVINE		181. SIGNATURE OF SACRED		182. SIGNATURE OF HOLY		183. SIGNATURE OF BLESSED		184. SIGNATURE OF BEATIFIED		185. SIGNATURE OF CANONIZED		186. SIGNATURE OF SAINT		187. SIGNATURE OF MARTYR		188. SIGNATURE OF CONFESSOR		189. SIGNATURE OF VIRGIN		190. SIGNATURE OF MONK		191. SIGNATURE OF NUN		192. SIGNATURE OF PRIEST		193. SIGNATURE OF BISHOP		194. SIGNATURE OF CARDINAL		195. SIGNATURE OF POPE		196. SIGNATURE OF KING		197. SIGNATURE OF QUEEN		198. SIGNATURE OF EMPEROR		199. SIGNATURE OF EMPRESS		200. SIGNATURE OF CAESAR		201. SIGNATURE OF CONQUEROR		202. SIGNATURE OF RULER		203. SIGNATURE OF LORD		204. SIGNATURE OF MASTER		205. SIGNATURE OF OWNER		206. SIGNATURE OF PROPRIETOR		207. SIGNATURE OF MANAGER		208. SIGNATURE OF SUPERVISOR		209. SIGNATURE OF DIRECTOR		210. SIGNATURE OF PRESIDENT		211. SIGNATURE OF VICE PRESIDENT		212. SIGNATURE OF CHAIRMAN		213. SIGNATURE OF MEMBER		214. SIGNATURE OF REPRESENTATIVE		215. SIGNATURE OF DELEGATE		216. SIGNATURE OF ATTORNEY		217. SIGNATURE OF LAWYER		218. SIGNATURE OF JUDGE		219. SIGNATURE OF CLERK		220. SIGNATURE OF SHERIFF		221. SIGNATURE OF CORONER		222. SIGNATURE OF JURY		223. SIGNATURE OF COURT		224. SIGNATURE OF STATE		225. SIGNATURE OF UNION		226. SIGNATURE OF COUNTY		227. SIGNATURE OF CITY		228. SIGNATURE OF TOWN		229. SIGNATURE OF VILLAGE		230. SIGNATURE OF HAMLET		231. SIGNATURE OF COUNTRY		232. SIGNATURE OF WORLD		233. SIGNATURE OF UNIVERSE		234. SIGNATURE OF GOD		235. SIGNATURE OF DEVIL		236. SIGNATURE OF ANGEL		237. SIGNATURE OF DEMON		238. SIGNATURE OF SPIRIT		239. SIGNATURE OF GHOST		240. SIGNATURE OF PHANTOM		241. SIGNATURE OF SPECTER		242. SIGNATURE OF GHOSTLY		243. SIGNATURE OF SPIRITUAL		244. SIGNATURE OF METAPHYSICAL		245. SIGNATURE OF SUPERNATURAL		246. SIGNATURE OF MIRACULOUS		247. SIGNATURE OF DIVINE		248. SIGNATURE OF SACRED		249. SIGNATURE OF HOLY		250. SIGNATURE OF BLESSED		251. SIGNATURE OF BEATIFIED		252. SIGNATURE OF CANONIZED		253. SIGNATURE OF SAINT		254. SIGNATURE OF MARTYR		255. SIGNATURE OF CONFESSOR		256. SIGNATURE OF VIRGIN		257. SIGNATURE OF MONK		258. SIGNATURE OF NUN		259. SIGNATURE OF PRIEST		260. SIGNATURE OF BISHOP		261. SIGNATURE OF CARDINAL		262. SIGNATURE OF POPE		263. SIGNATURE OF KING		264. SIGNATURE OF QUEEN		265. SIGNATURE OF EMPEROR		266. SIGNATURE OF EMPRESS		267. SIGNATURE OF CAESAR		268. SIGNATURE OF CONQUEROR		269. SIGNATURE OF RULER		270. SIGNATURE OF LORD		271. SIGNATURE OF MASTER		272. SIGNATURE OF OWNER		273. SIGNATURE OF PROPRIETOR		274. SIGNATURE OF MANAGER		275. SIGNATURE OF SUPERVISOR		276. SIGNATURE OF DIRECTOR		277. SIGNATURE OF PRESIDENT		278. SIGNATURE OF VICE PRESIDENT		279. SIGNATURE OF CHAIRMAN		280. SIGNATURE OF MEMBER		281. SIGNATURE OF REPRESENTATIVE		282. SIGNATURE OF DELEGATE		283. SIGNATURE OF ATTORNEY		284. SIGNATURE OF LAWYER		285. SIGNATURE OF JUDGE		286. SIGNATURE OF CLERK		287. SIGNATURE OF SHERIFF		288. SIGNATURE OF CORONER		289. SIGNATURE OF JURY		290. SIGNATURE OF COURT		291. SIGNATURE OF STATE		292. SIGNATURE OF UNION		293. SIGNATURE OF COUNTY		294. SIGNATURE OF CITY		295. SIGNATURE OF TOWN		296. SIGNATURE OF VILLAGE		297. SIGNATURE OF HAMLET		298. SIGNATURE OF COUNTRY		299. SIGNATURE OF WORLD		300. SIGNATURE OF UNIVERSE		301. SIGNATURE OF GOD		302. SIGNATURE OF DEVIL		303. SIGNATURE OF ANGEL		304. SIGNATURE OF DEMON		305. SIGNATURE OF SPIRIT		306. SIGNATURE OF GHOST		307. SIGNATURE OF PHANTOM		308. SIGNATURE OF SPECTER		309. SIGNATURE OF GHOSTLY		310. SIGNATURE OF SPIRITUAL		311. SIGNATURE OF METAPHYSICAL		312. SIGNATURE OF SUPERNATURAL		313. SIGNATURE OF MIRACULOUS		314. SIGNATURE OF DIVINE		315. SIGNATURE OF SACRED		316. SIGNATURE OF HOLY		317. SIGNATURE OF BLESSED		318. SIGNATURE OF BEATIFIED		319. SIGNATURE OF CANONIZED		320. SIGNATURE OF SAINT		321. SIGNATURE OF MARTYR		322. SIGNATURE OF CONFESSOR		323. SIGNATURE OF VIRGIN		324. SIGNATURE OF MONK		325. SIGNATURE OF NUN		326. SIGNATURE OF PRIEST		327. SIGNATURE OF BISHOP		328. SIGNATURE OF CARDINAL		329. SIGNATURE OF POPE		330. SIGNATURE OF KING		331. SIGNATURE OF QUEEN		332. SIGNATURE OF EMPEROR		333. SIGNATURE OF EMPRESS		334. SIGNATURE OF CAESAR		335. SIGNATURE OF CONQUEROR		336. SIGNATURE OF RULER		337. SIGNATURE OF LORD		338. SIGNATURE OF MASTER		339. SIGNATURE OF OWNER		340. SIGNATURE OF PROPRIETOR		341. SIGNATURE OF MANAGER		342. SIGNATURE OF SUPERVISOR		343. SIGNATURE OF DIRECTOR		344. SIGNATURE OF PRESIDENT		345. SIGNATURE OF VICE PRESIDENT		346. SIGNATURE OF CHAIRMAN		347. SIGNATURE OF MEMBER		348. SIGNATURE OF REPRESENTATIVE		349. SIGNATURE OF DELEGATE		350. SIGNATURE OF ATTORNEY		351. SIGNATURE OF LAWYER		352. SIGNATURE OF JUDGE		353. SIGNATURE OF CLERK		354. SIGNATURE OF SHERIFF		355. SIGNATURE OF CORONER		356. SIGNATURE OF JURY		357. SIGNATURE OF COURT		358. SIGNATURE OF STATE		359. SIGNATURE OF UNION		360. SIGNATURE OF COUNTY		361. SIGNATURE OF CITY		362. SIGNATURE OF TOWN		363. SIGNATURE OF VILLAGE		364. SIGNATURE OF HAMLET		365. SIGNATURE OF COUNTRY		366. SIGNATURE OF WORLD		367. SIGNATURE OF UNIVERSE		368. SIGNATURE OF GOD		369. SIGNATURE OF DEVIL		370. SIGNATURE OF ANGEL		371. SIGNATURE OF DEMON		372. SIGNATURE OF SPIRIT		373. SIGNATURE OF GHOST		374. SIGNATURE OF PHANTOM		375. SIGNATURE OF SPECTER		376. SIGNATURE OF GHOSTLY		377. SIGNATURE OF SPIRITUAL		378. SIGNATURE OF METAPHYSICAL		379. SIGNATURE OF SUPERNATURAL		380. SIGNATURE OF MIRACULOUS		381. SIGNATURE OF DIVINE		382. SIGNATURE OF SACRED		383. SIGNATURE OF HOLY		384. SIGNATURE OF BLESSED		385. SIGNATURE OF BEATIFIED		386. SIGNATURE OF CANONIZED		387. SIGNATURE OF SAINT		388. SIGNATURE OF MARTYR		389. SIGNATURE OF CONFESSOR		390. SIGNATURE OF VIRGIN		391. SIGNATURE OF MONK		392. SIGNATURE OF NUN		393. SIGNATURE OF PRIEST		394. SIGNATURE OF BISHOP		395. SIGNATURE OF CARDINAL		396. SIGNATURE OF POPE		397. SIGNATURE OF KING		398. SIGNATURE OF QUEEN		399. SIGNATURE OF EMPEROR		400. SIGNATURE OF EMPRESS		401. SIGNATURE OF CAESAR		402. SIGNATURE OF CONQUEROR		403. SIGNATURE OF RULER		404. SIGNATURE OF LORD		405. SIGNATURE OF MASTER		406. SIGNATURE OF OWNER		407. SIGNATURE OF PROPRIETOR		408. SIGNATURE OF MANAGER		409. SIGNATURE OF SUPERVISOR		410. SIGNATURE OF DIRECTOR		411. SIGNATURE OF PRESIDENT		412. SIGNATURE OF VICE PRESIDENT		413. SIGNATURE OF CHAIRMAN		414. SIGNATURE OF MEMBER		415. SIGNATURE OF REPRESENTATIVE		416. SIGNATURE OF DELEGATE		417. SIGNATURE OF ATTORNEY		418. SIGNATURE OF LAWYER		419. SIGNATURE OF JUDGE		420. SIGNATURE OF CLERK		421. SIGNATURE OF SHERIFF		422. SIGNATURE OF CORONER		423. SIGNATURE OF JURY		424. SIGNATURE OF COURT		425. SIGNATURE OF STATE		426. SIGNATURE OF UNION		427. SIGNATURE OF COUNTY		428. SIGNATURE OF CITY		429. SIGNATURE OF TOWN		430. SIGNATURE OF VILLAGE		431. SIGNATURE OF HAMLET		432. SIGNATURE OF COUNTRY		433. SIGNATURE OF WORLD		434. SIGNATURE OF UNIVERSE		435. SIGNATURE OF GOD		436. SIGNATURE OF DEVIL		437. SIGNATURE OF ANGEL		438. SIGNATURE OF DEMON		439. SIGNATURE OF SPIRIT		440. SIGNATURE OF GHOST		441. SIGNATURE OF PHANTOM		442. SIGNATURE OF SPECTER		443. SIGNATURE OF GHOSTLY		444. SIGNATURE OF SPIRITUAL		445. SIGNATURE OF METAPHYSICAL		446. SIGNATURE OF SUPERNATURAL		447. SIGNATURE OF MIRACULOUS		448. SIGNATURE OF DIVINE		449. SIGNATURE OF SACRED		450. SIGNATURE OF HOLY		451. SIGNATURE OF BLESSED		452. SIGNATURE OF BEATIFIED		453. SIGNATURE OF CANONIZED		454. SIGNATURE OF SAINT		455. SIGNATURE OF MARTYR		456. SIGNATURE OF CONFESSOR		457. SIGNATURE OF VIRGIN		458. SIGNATURE OF MONK		459. SIGNATURE OF NUN		460. SIGNATURE OF PRIEST		461. SIGNATURE OF BISHOP		462. SIGNATURE OF CARDINAL		463. SIGNATURE OF POPE		464. SIGNATURE OF KING		465. SIGNATURE OF QUEEN		466. SIGNATURE OF EMPEROR		467. SIGNATURE OF EMPRESS		468. SIGNATURE OF CAESAR		469. SIGNATURE OF CONQUEROR		470. SIGNATURE OF RULER		471. SIGNATURE OF LORD		472. SIGNATURE OF MASTER		473. SIGNATURE OF OWNER		474. SIGNATURE OF PROPRIETOR		475. SIGNATURE OF MANAGER		476. SIGNATURE OF SUPERVISOR		477. SIGNATURE OF DIRECTOR		478. SIGNATURE OF PRESIDENT		479. SIGNATURE OF VICE PRESIDENT		480. SIGNATURE OF CHAIRMAN		481. SIGNATURE OF MEMBER		482. SIGNATURE OF REPRESENTATIVE		483. SIGNATURE OF DELEGATE		484. SIGNATURE OF ATTORNEY		485. SIGNATURE OF LAWYER		486. SIGNATURE OF JUDGE		487. SIGNATURE OF CLERK		488. SIGNATURE OF SHERIFF		489. SIGNATURE OF CORONER		490. SIGNATURE OF JURY		491. SIGNATURE OF COURT		492. SIGNATURE OF STATE		493. SIGNATURE OF UNION		494. SIGNATURE OF COUNTY		495. SIGNATURE OF CITY		496. SIGNATURE OF TOWN		497. SIGNATURE OF VILLAGE		498. SIGNATURE OF HAMLET		499. SIGNATURE OF COUNTRY		500. SIGNATURE OF WORLD		501. SIGNATURE OF UNIVERSE		502. SIGNATURE OF GOD		503. SIGNATURE OF DEVIL		504. SIGNATURE OF ANGEL		505. SIGNATURE OF DEMON		506. SIGNATURE OF SPIRIT		507. SIGNATURE OF GHOST		508. SIGNATURE OF PHANTOM		509. SIGNATURE OF SPECTER		510. SIGNATURE OF GHOSTLY		511. SIGNATURE OF SPIRITUAL		512. SIGNATURE OF METAPHYSICAL		513. SIGNATURE OF SUPERNATURAL		514. SIGNATURE OF MIRACULOUS		515. SIGNATURE OF DIVINE		516. SIGNATURE OF SACRED		517. SIGNATURE OF HOLY		518. SIGNATURE OF BLESSED		519. SIGNATURE OF BEATIFIED		520. SIGNATURE OF CANONIZED		521. SIGNATURE OF SAINT		522. SIGNATURE OF MARTYR		523. SIGNATURE OF CONFESSOR		524. SIGNATURE OF VIRGIN		525. SIGNATURE OF MONK		526. SIGNATURE OF NUN		527. SIGNATURE OF PRIEST		528. SIGNATURE OF BISHOP		529. SIGNATURE OF CARDINAL		530. SIGNATURE OF POPE		531. SIGNATURE OF KING		532. SIGNATURE OF QUEEN		533. SIGNATURE OF EMPEROR		534. SIGNATURE OF EMPRESS		535. SIGNATURE OF CAESAR		536. SIGNATURE OF CONQUEROR		537. SIGNATURE OF RULER		538. SIGNATURE OF LORD		539. SIGNATURE OF MASTER		540. SIGNATURE OF OWNER		541. SIGNATURE OF PROPRIETOR		542. SIGNATURE OF MANAGER		543. SIGNATURE OF SUPERVISOR		544. SIGNATURE OF DIRECTOR		545. SIGNATURE OF PRESIDENT		546. SIGNATURE OF VICE PRESIDENT		547. SIGNATURE OF CHAIRMAN		548. SIGNATURE OF MEMBER		549. SIGNATURE OF REPRESENTATIVE		550. SIGNATURE OF DELEGATE		551. SIGNATURE OF ATTORNEY		552. SIGNATURE OF LAWYER		553. SIGNATURE OF JUDGE		554. SIGNATURE OF CLERK		555. SIGNATURE OF SHERIFF		556. SIGNATURE OF CORONER		557. SIGNATURE OF JURY		558. SIGNATURE OF COURT		559. SIGNATURE OF STATE		560. SIGNATURE OF UNION		561. SIGNATURE OF COUNTY		562. SIGNATURE OF CITY		563. SIGNATURE OF TOWN		564. SIGNATURE OF VILLAGE		565. SIGNATURE OF HAMLET		566. SIGNATURE OF COUNTRY		567. SIGNATURE OF WORLD		568. SIGNATURE OF UNIVERSE		569. SIGNATURE OF GOD		570. SIGNATURE OF DEVIL		571. SIGNATURE OF ANGEL		572. SIGNATURE OF DEMON		573. SIGNATURE OF SPIRIT		574. SIGNATURE OF GHOST		575. SIGNATURE OF PHANTOM		576. SIGNATURE OF SPECTER		577. SIGNATURE OF GHOSTLY		578. SIGNATURE OF SPIRITUAL		579. SIGNATURE OF METAPHYSICAL		580. SIGNATURE OF SUPERNATURAL		581. SIGNATURE OF MIRACULOUS		582. SIGNATURE OF DIVINE		583. SIGNATURE OF SACRED		584. SIGNATURE OF HOLY		585. SIGNATURE OF BLESSED		586. SIGNATURE OF BEATIFIED		587. SIGNATURE OF CANONIZED		588. SIGNATURE OF SAINT		589. SIGNATURE OF MARTYR		590. SIGNATURE OF CONFESSOR		591. SIGNATURE OF VIRGIN		592. SIGNATURE OF MONK		593. SIGNATURE OF NUN		594. SIGNATURE OF PRIEST		595. SIGNATURE OF BISHOP		596. SIGNATURE OF CARDINAL		597. SIGNATURE OF POPE		598. SIGNATURE OF KING		599. SIGNATURE OF QUEEN		600. SIGNATURE OF EMPEROR		601. SIGNATURE OF EMPRESS		602. SIGNATURE OF CAESAR		603. SIGNATURE OF CONQUEROR		604. SIGNATURE OF RULER		605. SIGNATURE OF LORD		606. SIGNATURE OF MASTER		607. SIGNATURE OF OWNER		608. SIGNATURE OF PROPRIETOR		609. SIGNATURE OF MANAGER		610. SIGNATURE OF SUPERVISOR		611. SIGNATURE OF DIRECTOR		612. SIGNATURE OF PRESIDENT		613. SIGNATURE OF VICE PRESIDENT		614. SIGNATURE OF CHAIRMAN		615. SIGNATURE OF MEMBER		616. SIGNATURE OF REPRESENTATIVE		617. SIGNATURE OF DELEGATE		618. SIGNATURE OF ATTORNEY		619. SIGNATURE OF LAWYER		620. SIGNATURE OF JUDGE		621. SIGNATURE OF CLERK		622. SIGNATURE OF SHERIFF		623. SIGNATURE OF CORONER		624. SIGNATURE OF JURY		625. SIGNATURE OF COURT		626. SIGNATURE OF STATE		627. SIGNATURE OF UNION		628. SIGNATURE OF COUNTY		629. SIGNATURE OF CITY		630. SIGNATURE OF TOWN		631. SIGNATURE OF VILLAGE		632. SIGNATURE OF HAMLET		633. SIGNATURE OF COUNTRY		634. SIGNATURE OF WORLD		635. SIGNATURE OF UNIVERSE		636. SIGNATURE OF GOD		637. SIGNATURE OF DEVIL		638. SIGNATURE OF ANGEL		639. SIGNATURE OF DEMON		640. SIGNATURE OF SPIRIT		641. SIGNATURE OF GHOST		642. SIGNATURE OF PHANTOM		643. SIGNATURE OF SPECTER		644. SIGNATURE OF GHOSTLY		645. SIGNATURE OF SPIRITUAL		646. SIGNATURE OF METAPHYSICAL		647. SIGNATURE OF SUPERNATURAL		648. SIGNATURE OF MIRACULOUS		649. SIGNATURE OF DIVINE		650. SIGNATURE OF SACRED		651. SIGNATURE OF HOLY		652. SIGNATURE OF BLESSED		653. SIGNATURE OF BEATIFIED		654. SIGNATURE OF CANONIZED		655. SIGNATURE OF SAINT		656. SIGNATURE OF MARTYR		657. SIGNATURE OF CONFESSOR		658. SIGNATURE OF VIRGIN		659. SIGNATURE OF MONK		660. SIGNATURE OF NUN		661. SIGNATURE OF PRIEST		662. SIGNATURE OF BISHOP		663. SIGNATURE OF CARDINAL		664. SIGNATURE OF POPE		665. SIGNATURE OF KING		666. SIGNATURE OF QUEEN		667. SIGNATURE OF EMPEROR		668. SIGNATURE OF EMPRESS		669. SIGNATURE OF CAESAR		670. SIGNATURE OF CONQUEROR		671. SIGNATURE OF RULER		672. SIGNATURE OF LORD		673. SIGNATURE OF MASTER		674. SIGNATURE OF OWNER		675. SIGNATURE OF PROPRIETOR		676. SIGNATURE OF MANAGER		677. SIGNATURE OF SUPERVISOR		678. SIGNATURE OF DIRECTOR		679. SIGNATURE OF PRESIDENT		680. SIGNATURE OF VICE PRESIDENT		681. SIGNATURE OF CHAIRMAN		682. SIGNATURE OF MEMBER		683. SIGNATURE OF REPRESENTATIVE		684. SIGNATURE OF DELEGATE		685. SIGNATURE OF ATTORNEY		686. SIGNATURE OF LAWYER		687. SIGNATURE OF JUDGE		688. SIGNATURE OF CLERK		689. SIGNATURE OF SHERIFF		690. SIGNATURE OF CORONER		691. SIGNATURE OF JURY		692. SIGNATURE OF COURT		693. SIGNATURE OF STATE		694. SIGNATURE OF UNION		695. SIGNATURE OF COUNTY		696. SIGNATURE OF CITY		697. SIGNATURE OF TOWN		698. SIGNATURE OF VILLAGE		699. SIGNATURE OF HAMLET		700. SIGNATURE OF COUNTRY		701. SIGNATURE OF WORLD		702. SIGNATURE OF UNIVERSE		703. SIGNATURE OF GOD		704. SIGNATURE OF DEVIL		705. SIGNATURE OF ANGEL		706. SIGNATURE OF DEMON		707. SIGNATURE OF SPIRIT		708. SIGNATURE OF GHOST		709. SIGNATURE OF PHANTOM		710. SIGNATURE OF SPECTER		711. SIGNATURE OF GHOSTLY		712. SIGNATURE OF SPIRITUAL		713. SIGNATURE OF METAPHYSICAL		714. SIGNATURE OF SUPERNATURAL	
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10373

CERTIFICATE OF DEATH

Reg. Dist. No. 10033

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>10 years</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Indian Head, Maryland 08x2.2</u> d. STREET ADDRESS <u>1413 Straus Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last (Junior) <u>Charles Ignatius Mattingly</u>				4. DATE OF DEATH Month Day Year <u>10 20 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/14/35</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Charles Ignatius Mattingly</u>				14. MOTHER'S MAIDEN NAME <u>Mary Madeline Nalley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Rosewood Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>status epilepticus</u> <u>353.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/25/</u> , 19 <u>57</u> , to <u>10/20/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20/</u> , 19 <u>57</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Rosewood State Training School</u> <u>10/21/57</u>							
ACTUAL SIGNATURE <u>Conrado Bogaert</u> M.D. <u>Rosewood State Training School</u>				PHYSICIAN'S NAME (Type) <u>Conrado Bogaert, M.D.</u> <u>Rosewood State Training School</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-23-57</u>		<u>St Charles</u>		<u>Stemont Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Crehart Inc</u> ADDRESS <u>Laplatam</u>				24a. REC'D BY REGISTRAR DATE <u>10/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Pansy</u> <u>Mary Elms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARKLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10008

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. EDUCATION		10. RELIGION		11. SOCIAL CLASS		12. CAUSE OF DEATH	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. PLACE OF INTERMENT		17. NAME OF FUNERAL HOME		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF MINISTER		23. SIGNATURE OF CHURCH		24. SIGNATURE OF OTHER	

BUREAU V. A.

OCT 28 1957

RECEIVED

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10374

CERTIFICATE OF DEATH

10363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		d. STREET ADDRESS 209 E. Lafayette Ave.	
3. NAME OF DECEASED (Type or print) First Joseph Middle W. Last May		4. DATE OF DEATH Month October Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1976
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 8 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. May		14. MOTHER'S MAIDEN NAME Mary C. Waite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Richard May		Address Manor Road - Glen Arm Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial hypertrophy with failure. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis chronic DUE TO (c) Arteriosclerosis generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left ventricular enlargement with some asthma signs. INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> no injury	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no injury		20f. (City or town) (County) (State) no injury	
21. I certify that I attended the deceased from June , 1957, to October 19th, 1957 , that I last saw the deceased alive on October 19 , 1957, and that death occurred at 5.50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 516 Cathedral Street Baltimore I Maryland DATE SIGNED 10-22-57 ACTUAL SIGNATURE James Graham Marston, M.D. PHYSICIAN'S NAME (Type) James Graham Marston, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR Oct 25 57		24b. REGISTRAR'S SIGNATURE Oct 25 57	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

BUREAU V. 3

OCT 25 1957

RECEIVED

10375

CERTIFICATE OF DEATH

10364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 7 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7116 Campfield Road		d. STREET ADDRESS 7116 Campfield Road	
3. NAME OF DECEASED (Type or print) First James Middle McClelland Last		4. DATE OF DEATH Month Oct Day 26 Year 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John McClelland		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. L. Eva McClelland		Address 7116 Campfield Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x 2 Cerebral Hemorrhages DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 23 days 15 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 10/26/57 , that I last saw the deceased alive on 10/25/57 , and that death occurred at 5:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE H. V. Harper M.D. 5701 Luray Avenue			
PHYSICIAN'S NAME (Type) H. V. HARPER			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/29/57	London Park	Balto MD
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 5005 Pl. Heights	
24a. REC'D BY REGISTRAR 10/29/57		24b. REGISTRAR'S SIGNATURE Dr. J. M. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

, 10376

CERTIFICATE OF DEATH

Reg. Dist. No. 103658

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO. CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE X0</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2918 POTTY HILL AVE</u>				d. STREET ADDRESS <u>2918 POTTY HILL AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>D.</u> Last <u>McGUTCHEN</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 29, 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>FREDERICK SCHNEIDER</u>				14. MOTHER'S MAIDEN NAME <u>MARY RODIEGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mrs. ELIZABETH BARDOFF</u> Address <u>2918 POTTY HILL AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>10/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/7</u> , 19 <u>57</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Joseph S. Blum MD</u> M.D. <u>10/8/57</u> PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u> <u>115 N. CALVERT ST. BALTO.-MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>OCT 11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Locust Park National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CLIPICH FUNERAL HOME BALTO. MD</u> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>10/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

CERTIFICATE OF DEATH

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OCT 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1036638
Reg. Dist. No.

10377

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7530 BELLONA AVE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XORXTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7530 BELLONA AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>R</u> Last <u>McKEWEN</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 13, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>THOMAS RODOY</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET FINNIAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM F. McKEWEN</u> Address <u>7530 BELLONA AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Broncho</u> <u>462.1</u> DUE TO <u>Emphysema Varicose, Ruptured</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arthritis Rheumatoid</u> (c) <u>Unk.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>10/15</u> , 19 <u>57</u> , to <u>10/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/17</u> , 19 <u>57</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennett A. Stoen</u> M.D.				ADDRESS (Street, city or town, state) <u>Lutherville</u>			
PHYSICIAN'S NAME (Type) <u>Bennett A. Stoen</u>				DATE SIGNED <u>10/18/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CALHEDRA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Grawe</u>				ADDRESS <u>118 W. Mt. Royal Ave.</u>		24a. REC'D BY REGISTRAR <u>Michael Guy</u>	
24b. REGISTRAR'S SIGNATURE <u>Michael Guy</u>				DATE <u>OCT 21 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. MARITAL STATUS	
13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA	
16. PREVIOUS DRUGS		17. PREVIOUS ALCOHOL		18. PREVIOUS TOBACCO	
19. PREVIOUS RADIATION		20. PREVIOUS CHEMOTHERAPY		21. PREVIOUS HORMONES	
22. PREVIOUS TRANSFUSIONS		23. PREVIOUS ORGANS		24. PREVIOUS TISSUES	
25. PREVIOUS CELLS		26. PREVIOUS BLOOD		27. PREVIOUS URINE	
28. PREVIOUS SWEAT		29. PREVIOUS SALIVA		30. PREVIOUS TEARS	
31. PREVIOUS SPOOLS		32. PREVIOUS EGGS		33. PREVIOUS CYSTES	
34. PREVIOUS PARASITES		35. PREVIOUS FUNGI		36. PREVIOUS BACTERIA	
37. PREVIOUS VIRUSES		38. PREVIOUS PRIONS		39. PREVIOUS TOXINS	
40. PREVIOUS ANTIBODIES		41. PREVIOUS ANTIGENS		42. PREVIOUS ENZYMES	
43. PREVIOUS HORMONES		44. PREVIOUS NEUROTRANSMITTERS		45. PREVIOUS GROWTH FACTORS	
46. PREVIOUS CYTOKINES		47. PREVIOUS CHEMOKINES		48. PREVIOUS ADIPOKINES	
49. PREVIOUS INTERLEUKINS		50. PREVIOUS INTERFERONS		51. PREVIOUS TUMOR MARKERS	
52. PREVIOUS CARCINOGENS		53. PREVIOUS MUTAGENS		54. PREVIOUS TERATOGENS	
55. PREVIOUS TERATOGENS		56. PREVIOUS TERATOGENS		57. PREVIOUS TERATOGENS	
58. PREVIOUS TERATOGENS		59. PREVIOUS TERATOGENS		60. PREVIOUS TERATOGENS	
61. PREVIOUS TERATOGENS		62. PREVIOUS TERATOGENS		63. PREVIOUS TERATOGENS	
64. PREVIOUS TERATOGENS		65. PREVIOUS TERATOGENS		66. PREVIOUS TERATOGENS	
67. PREVIOUS TERATOGENS		68. PREVIOUS TERATOGENS		69. PREVIOUS TERATOGENS	
70. PREVIOUS TERATOGENS		71. PREVIOUS TERATOGENS		72. PREVIOUS TERATOGENS	
73. PREVIOUS TERATOGENS		74. PREVIOUS TERATOGENS		75. PREVIOUS TERATOGENS	
76. PREVIOUS TERATOGENS		77. PREVIOUS TERATOGENS		78. PREVIOUS TERATOGENS	
79. PREVIOUS TERATOGENS		80. PREVIOUS TERATOGENS		81. PREVIOUS TERATOGENS	
82. PREVIOUS TERATOGENS		83. PREVIOUS TERATOGENS		84. PREVIOUS TERATOGENS	
85. PREVIOUS TERATOGENS		86. PREVIOUS TERATOGENS		87. PREVIOUS TERATOGENS	
88. PREVIOUS TERATOGENS		89. PREVIOUS TERATOGENS		90. PREVIOUS TERATOGENS	
91. PREVIOUS TERATOGENS		92. PREVIOUS TERATOGENS		93. PREVIOUS TERATOGENS	
94. PREVIOUS TERATOGENS		95. PREVIOUS TERATOGENS		96. PREVIOUS TERATOGENS	
97. PREVIOUS TERATOGENS		98. PREVIOUS TERATOGENS		99. PREVIOUS TERATOGENS	
100. PREVIOUS TERATOGENS		101. PREVIOUS TERATOGENS		102. PREVIOUS TERATOGENS	

BUREAU V. B.

OCT 21 1957

RECEIVED

10378

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Oella</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westchester Ave.</u>		d. STREET ADDRESS <u>Westchester Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>A.</u> Last <u>Mc Kittrick</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Home</u>	11. BIRTHPLACE (State or foreign country) <u>Ireland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry McKittrick</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Jane Finigan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. Julia Debaugh Westchester Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1 Arteriosclerotic Cardio Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-7-54</u> , 19 <u>54</u> , to <u>10-8-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-7-57</u> , 19 <u>57</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Burgtorf</u> M.D.		DATE SIGNED <u>42 Church St. Ellicott City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE E. BURGTORF M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cem/</u>	22d. LOCATION (City, town, or county) (State) <u>Texas Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 11 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe c. LENGTH OF STAY IN lb 20 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Baltimore COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1315 Sulphur Spring Rd.		d. STREET ADDRESS 1315 Sulphur Spring Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sophia (NMI) Melvin		4. DATE OF DEATH Month Day Year October 29, 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME August Yeager		14. MOTHER'S MAIDEN NAME Betty Wagner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Charles E. Melvin 1315 Sulphur Sp. Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to Oct 29, 1957 , that I last saw the deceased alive on Oct 28, 1957 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE I. EARL PASS M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4001 Wilkens Ave Baltimore Md	
PHYSICIAN'S NAME (Type) I. EARL PASS		4001 Wilkens Ave Baltimore Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 1, 1957	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Amelia, Inc. 1328 Sulphur Sp. Rd.		24a. REC'D BY REGISTRAR NOV 4 1957	
24b. REGISTRAR'S SIGNATURE Dr. G. M. Kieffer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

City of Baltimore

Deceased's Name

Age

Sex

Place of Birth

Date of Birth

October 24, 1907

Joseph (JIM) Melvin

April 27, 1911

Female White

Married

Own home

House work

Next of Kin

August 1957

Charles E. Melvin 1115 Sulphur Spring Rd.

None

No

BUREAU V. S.

NOV 4 1957

RECEIVED

NOV 1, 1957 London Park

10379

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 6mths9dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 VOI-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 914 Kevin Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Messina Last Messina		4. DATE OF DEATH Month October Day 1 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fruit grower		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 30 , 19 57 , to Oct. 1 , 19 57 , that I last saw the deceased alive on Oct. 1 , 19 57 , and that death occurred at 4:00p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 10-1-57			
ACTUAL SIGNATURE Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 10-1-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 4, 1957	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. O. Mitchell & Sons		24a. OCT BY REGISTRAR 37 24b. REGISTRAR'S SIGNATURE W. H. Leach	
DATE			

John O. Mitchell & Sons 1900 Eutaw Place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		OCTOBER 4, 1957	
AGE		SEX	
65		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JANUARY 1, 1892		Maryland	
MARRIAGE DATE		MARRIAGE PLACE	
JANUARY 1, 1915		Maryland	
OCCUPATION		CAUSE OF DEATH	
Retired		Heart Disease	
EDUCATION		MANNER OF DEATH	
High School		Natural	
RELIGION		PLACE OF DEATH	
Roman Catholic		Home	
PREVIOUS ILLNESS		DATE OF BURIAL	
None		OCTOBER 10, 1957	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	

BUREAU V. S.

OCT 4 1957

RECEIVED

10380

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 16 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Nursing Home, Harlem Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marchie Middle Millard Last 		4. DATE OF DEATH Month Oct. Day 29 Year 1957	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Knight		14. MOTHER'S MAIDEN NAME Lisa Morton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. Ruth Long		Address Wash 308 6536 Capital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure. 9047 DUE TO Pulmonary oedema, Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture right hip. Accident due to injury (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) How accident was caused not known. Possibly a fall	
20c. TIME OF INJURY Month, Day, Year Hour Abt Oct. 1, 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Nursing Home	20f. (City or town) Catonsville (County) Balto. (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo M Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-1-57	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or county) (State) 3201 Bladensburg Road Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin		ADDRESS 1902 Eutaw Place Baltimore 17, Maryland	
24a. REC'D BY REGISTRAR BOX 1 '57		24b. REGISTRAR'S SIGNATURE Q. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 12 1957

BUREAU V. S.

10261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7215 Dunmar Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CAROLINE Middle A. Last MILLER				4. DATE OF DEATH Month October Day 25, Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 28, 1872	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sweden	
12. CITIZEN OF WHAT COUNTRY? U.S. A.							
13. FATHER'S NAME Peter Anderson				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Marie Allertof 7213 Dunmar Court	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart Disease 420.0 DUE TO (b) Generalized Arteriosclerosis DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 20 years 25 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoporosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6:54 , 19 57 , to 10 , 19 57 , that I last saw the deceased alive on 10-25-57 , 19 57 , and that death occurred at 11 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE JACK C Collins				ADDRESS (Street, city or town, state) 2 Kears Rps Balt 22			
PHYSICIAN'S NAME (Type) JACK C Collins				DATE SIGNED 10-26-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF October 26, '57		22c. NAME OF CEMETERY OR CREMATORY Brandywine Cemetery		22d. LOCATION (City, town, or county) (State) Braddock, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Dundalk, Md.				24a. REC'D BY REGISTRAR 10-29-57			
				24b. REGISTRAR'S SIGNATURE Wm. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF TOWNSHIP CLERK</p>		<p>20. SIGNATURE OF COUNTY CLERK</p>	
<p>21. SIGNATURE OF STATE CLERK</p>		<p>22. SIGNATURE OF DEPARTMENT CLERK</p>		<p>23. SIGNATURE OF HEALTH COMMISSIONER</p>		<p>24. SIGNATURE OF GOVERNOR</p>	

BUREAU V. S.

OCT 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10381

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 119 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last MILLER				4. DATE OF DEATH Month October Day 2 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 3, 1899	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George R. Miller				14. MOTHER'S MAIDEN NAME Margaretha A. Magel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 217-14-5894		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, PRIMARY SITE UNDETERMINED 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation - 6/25/57- Excision of mass, left neck							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 5, 1957 to October 2, 1957 and that death occurred at 6:10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Irving Freeman M.D. VETERANS ADMINISTRATION HOSPITAL 10/2/57 PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B.L. Hopping & Sons, 170 West St. Annapolis, Md.				24a. REC'D BY REGISTRAR OCT 7 1957		24b. REGISTRAR'S SIGNATURE Wm. L. Farber	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

BUREAU V. 3

OCT 7 1957

RECEIVED

Order 51111

Oct. 1, 1957

BUREAU V. S.

2501 6 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10374

10383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6yr10mth15days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4			
4. DATE OF DEATH Month October Day 7 Year 19 57				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Katherine Middle Rohe Last Miller				5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH October, 1887				9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary ??			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from Aug. 23 19 57 , to Oct. 7 19 57 , that I last saw the deceased alive on Oct. 7 19 57 , and that death occurred at 11:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-7-57							
ACTUAL SIGNATURE Stella Wachslar M.D.				PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Fullerton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sarah Fund Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR OCT 14 '57	
				24b. REGISTRAR'S SIGNATURE W. L. Smith			

CERTIFICATE OF DEATH

BUREAU V. 2

OCT 14 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Monkton Road				d. STREET ADDRESS Monkton Road			
3. NAME OF DECEASED (Type or print) First RUBY Middle E. Last MILLER				4. DATE OF DEATH Month October Day 17 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1894	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Edward Reichard				14. MOTHER'S MAIDEN NAME Minnie C. Payton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 24 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1954 to Oct 1957 that I last saw the deceased alive on 17 October 1957 and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Hees				ADDRESS (Street, city or town, state) Cockeysville Md 10-17-57			
PHYSICIAN'S NAME (Type) WALTER T. HEES				DATE SIGNED Cockeysville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Hereford Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Hereford, Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons				ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR OCT 23 57	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		BALTIMORE	
DATE OF DEATH		OCTOBER 17, 1957	
PLACE OF DEATH		BALTIMORE	
AGE		62	
SEX		MALE	
RACE		WHITE	
OCCUPATION		RETIRED	
EDUCATION		HIGH SCHOOL	
MARRIAGE		MARRIED	
SPOUSE		JENNIFER ANN	
CHILDREN		JOHN EDWARD, JR.	
FATHER		JOHN EDWARD, SR.	
MOTHER		JENNIFER ANN	
BIRTH		OCTOBER 17, 1895	
PLACE OF BIRTH		BALTIMORE	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. EDWARD	
SIGNATURE OF DEATH REGISTRAR		J. EDWARD	
SIGNATURE OF WITNESS		J. EDWARD	
SIGNATURE OF DECEASED		J. EDWARD	

BUREAU V. S.

OCT 23 1957

RECEIVED

10385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 2yr10mth22dys				d. STREET ADDRESS 27 N. Carey Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harley Middle Milliron Last Milliron				4. DATE OF DEATH Month October Day 7 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 27 , 19 57 to Oct. 7 , 19 57 , that I last saw the deceased alive on Oct. 7 , 19 57 , and that death occurred at 7.25P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-8-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/57		22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) Balt. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marhatt & Son 28				ADDRESS 28		24a. REC'D BY REGISTRAR DACT 14 '57	
				24b. REGISTRAR'S SIGNATURE Quench			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 2

OCT 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10377

10386

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave.		d. STREET ADDRESS 608 Edgewood St	
3. NAME OF DECEASED (Type or print) First John Middle Moelter Last		4. DATE OF DEATH Month Oct. Day 20 , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1874
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired tailor		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ---Moelter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219 22 5329 A	
17. INFORMANT Mrs. Mollie Moelter		Address 608 Edgewood St	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis (?) years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH one day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to 10/20 , 19 57 , that I last saw the deceased alive on 10/16 , 19 57 , and that death occurred at 2 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED E. P. WILLIAMSON, M.D. 10/22/57 3334 EDMONDSON AVENUE BALTIMORE 18, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23/57	
22c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors		24. REC'D BY REGISTRAR DATE 10/13/57	
ADDRESS 4101 Edmondson		24b. REGISTRAR'S SIGNATURE A. H. Reduch	

CERTIFICATE OF DEATH

1957

Reg. Dist. No.

1. PLACE OF DEATH
2. SEX
3. AGE
4. DATE OF BIRTH
5. MARITAL STATUS
6. OCCUPATION
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. DATE OF DEATH
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF CORONER
14. SIGNATURE OF JURY
15. SIGNATURE OF JUDGE

16. SIGNATURE OF REGISTRAR
17. SIGNATURE OF PHYSICIAN
18. SIGNATURE OF CORONER
19. SIGNATURE OF JURY
20. SIGNATURE OF JUDGE

BUREAU V. S.

OCT 24 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10387

CERTIFICATE OF DEATH

Reg. Dist. No.

10378 38

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 WASHINGTON AVE		d. STREET ADDRESS 214 WASHINGTON AVE	
3. NAME OF DECEASED (Type or print) First MINNIE Middle E. Last MOLESWORTH		4. DATE OF DEATH Month OCT. Day 6 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 13 1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) HOWARD CO. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN W. LEWIS	
14. MOTHER'S MAIDEN NAME ELIZABETH BUTLER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		17. INFORMANT Address MRS ROBERT G. WARFIELD - TOWSON - MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis (c) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1957 to Oct 6, 1957 that I last saw the deceased alive on Oct 5, 1957 , and that death occurred at 6:14 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George T. Gilmore M.D.		ADDRESS (Street, city or town, state) Lutherville, Md. DATE SIGNED 10/7/57	
PHYSICIAN'S NAME (Type) GEORGE T. GILMORE		LUTHERVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Poplar Springs Meth.	22d. LOCATION (City, town, or county) (State) Poplar Springs, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE 9 1957	24b. REGISTRAR'S SIGNATURE Mabel Gray

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN W. HARRIS</i>		2. SEX <i>Male</i>	
3. AGE <i>62</i>		4. DATE OF BIRTH <i>Jan 15 1893</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. NAME OF SPOUSE <i>Martha J. Harris</i>	
9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. TIME OF DEATH <i>10:15 AM</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
13. SIGNATURE OF WITNESSES <i>John W. Harris</i>		14. SIGNATURE OF DECEASED <i>John W. Harris</i>	
15. SIGNATURE OF REGISTRAR <i>John W. Harris</i>		16. SIGNATURE OF CLERK <i>John W. Harris</i>	
17. SIGNATURE OF JURY <i>John W. Harris</i>		18. SIGNATURE OF JUDGE <i>John W. Harris</i>	
19. SIGNATURE OF SHERIFF <i>John W. Harris</i>		20. SIGNATURE OF CORONER <i>John W. Harris</i>	
21. SIGNATURE OF DISTRICT ATTORNEY <i>John W. Harris</i>		22. SIGNATURE OF COUNTY CLERK <i>John W. Harris</i>	
23. SIGNATURE OF STATE CLERK <i>John W. Harris</i>		24. SIGNATURE OF SECRETARY <i>John W. Harris</i>	
25. SIGNATURE OF ASSISTANT SECRETARY <i>John W. Harris</i>		26. SIGNATURE OF CHIEF CLERK <i>John W. Harris</i>	
27. SIGNATURE OF DEPUTY CLERK <i>John W. Harris</i>		28. SIGNATURE OF RECORDS CLERK <i>John W. Harris</i>	
29. SIGNATURE OF FILE CLERK <i>John W. Harris</i>		30. SIGNATURE OF INDEX CLERK <i>John W. Harris</i>	
31. SIGNATURE OF RECEPTION CLERK <i>John W. Harris</i>		32. SIGNATURE OF DISTRIBUTION CLERK <i>John W. Harris</i>	
33. SIGNATURE OF RETURN CLERK <i>John W. Harris</i>		34. SIGNATURE OF FILING CLERK <i>John W. Harris</i>	
35. SIGNATURE OF CLERK IN CHARGE <i>John W. Harris</i>		36. SIGNATURE OF CLERK AT LARGE <i>John W. Harris</i>	
37. SIGNATURE OF CLERK OF THE HOUSE <i>John W. Harris</i>		38. SIGNATURE OF CLERK OF THE SENATE <i>John W. Harris</i>	
39. SIGNATURE OF CLERK OF THE SUPREME COURT <i>John W. Harris</i>		40. SIGNATURE OF CLERK OF THE DISTRICT COURT <i>John W. Harris</i>	
41. SIGNATURE OF CLERK OF THE COUNTY COURT <i>John W. Harris</i>		42. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
43. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		44. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
45. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		46. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
47. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		48. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
49. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		50. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
51. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		52. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
53. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		54. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
55. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		56. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
57. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		58. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
59. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		60. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
61. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		62. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
63. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		64. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
65. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		66. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
67. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		68. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
69. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		70. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
71. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		72. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
73. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		74. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
75. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		76. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
77. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		78. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
79. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		80. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
81. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		82. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
83. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		84. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
85. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		86. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
87. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		88. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
89. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		90. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
91. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		92. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
93. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		94. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	
95. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>		96. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>	
97. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>		98. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT <i>John W. Harris</i>	
99. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT <i>John W. Harris</i>		100. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT <i>John W. Harris</i>	

RECEIVED
OCT 9 1957
BUREAU V. S.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 N. Beechwood Ave				d. STREET ADDRESS 207 N. Beechwood Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Dolores Middle J. Monaghan Last				4. DATE OF DEATH Month Oct. Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Billing Machine Operator, Schloss Bros. Balto. Md				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Geo. Nabighurst				14. MOTHER'S MAIDEN NAME Mary Gobrigh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 215 01 8581			
17. INFORMANT Mrs. Joseph Codd, 207 N. Beechwood Ave				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive Cardio-Vascular Disease (c) years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH in sleep							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August , 19 57 , to Oct. 15 , 19 57 , that I last saw the deceased alive on Oct. 14 , 19 57 , and that death occurred at 5:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis R. Moser				ADDRESS (Street, city or town, state) 4335 Park Heights Ave			
PHYSICIAN'S NAME (Type) M.D.				DATE SIGNED 10/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 18/57			
22c. NAME OF CEMETERY OR CREMATORY New Cathedral				22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave				24a. REC'D BY REGISTRAR OCT 18 57			
24b. REGISTRAR'S SIGNATURE Outman							

BUREAU V. S.

OCT 18 1957

RECEIVED

10389
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10380

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11511 Reisterstown, Rd.		d. STREET ADDRESS 11511 Reisterstown Rd.	
3. NAME OF DECEASED (Type or print) First Ellen Middle E. Last Moser		4. DATE OF DEATH Month Oct. Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Strine		14. MOTHER'S MAIDEN NAME Mary L. Wenrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ruth Chaney Owings Mills		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure, Chronic DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis - generalized CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 years 15 years 20 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 53 , to October 24 , 19 57 , that I last saw the deceased alive on October 24 , 19 57 , and that death occurred at 2:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown, Maryland DATE SIGNED Oct. 24/1957 ACTUAL SIGNATURE Clarence E. McWilliams M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28/57	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons Reisterstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR 10 24-57		24b. REGISTRAR'S SIGNATURE Mary B Eline	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		1957	
Age		Sex	
35 Years		Male	
Place of Birth		Date of Birth	
Baltimore, Md.		1922	
Usual Residence		Cause of Death	
Baltimore, Md.		Heart Disease	
Occupation		Manner of Death	
Teacher		Natural	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date		Place	
1957		Baltimore, Md.	

RECEIVED
OCT 28 1957
BUREAU V. 2

10390

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10861 Dist

No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Fort Howard, Md.</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural, give location) <u>132 N. Ellwood Avenue</u>			
3. NAME OF DECEASED: (First) <u>JOSEPH</u>		(Middle) <u>D.</u>		(Last) <u>MUELLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 4, 19 57</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>December 7, 1923</u>	9. AGE last birthday: <u>33</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Department Store</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Mueller</u>				14. MOTHER'S MAIDEN NAME: <u>Theresa Connelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No.: <u>217 12 7355</u>		17. INFORMANT & ADDRESS: <u>Joseph J. Mueller 132 N. Ellwood Ave.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
<u>900.0</u> Immediate cause (a) <u>FRACTURE OF OCCIPITAL BONE AND INTERCEREBRAL AND DUE TO SUBARACHNOID HEMORRHAGE</u> Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>10/3/57</u>		19b. MAJOR FINDING OF OPERATION: <u>Fracture Occiput subarachnoid hemorrhage</u>		20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Baltimore, Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Sept 30, 57</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down steps</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. E. Baermann, MD</u>		M. D. <u>W. E. Baermann, M. D.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/4/57</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 9, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>10/5/57</u>		REGISTRAR'S SIGNATURE <u>Dawson & Lark</u>		24. FUNERAL DIRECTOR <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore St., Balto., Md.</u>	

VS. A15A - 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

BUREAU V. E.

OCT 9 1957

RECEIVED

10391

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE 1224.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				d. STREET ADDRESS 600, REVOLUTION ST.			
3. NAME OF DECEASED (Type or print) First MYRTLE Middle MAE Last MURPHY				4. DATE OF DEATH Month 10 Day 8 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/04	
9. AGE (In years last birthday) 52 yts.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES MILLER				14. MOTHER'S MAIDEN NAME LAURA WARFEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PLEURAL ENDOTHELIOMA 197X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/29 , 19 57 , to 10/8 , 19 57 , that I last saw the deceased alive on 10/8 , 19 57 , and that death occurred at 11-10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland							
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent Mt. Wilson - Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/11/57		Angel Hill		Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Newcomer, M.D.				24a. REC'D BY REGISTRAR DATE 10-10-57		24b. REGISTRAR'S SIGNATURE Dorothy Newell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 3

OCT 11 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10383

10392

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3 Vol 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Towson Nursing Home</i>		d. STREET ADDRESS <i>Former 4108 Mary Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Catherine</i> First Middle Last		4. DATE OF DEATH <i>October 31st</i> 1957 Month Day Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 3, 1873</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John P. Mc Evoy</i>		14. MOTHER'S MAIDEN NAME <i>Mary Brady</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Charles P. Kilduff</i> Address <i>811 South wick</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PERNICIOUS ANEMIA</i> <i>290.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>GENERALIZED ARTERIOSCLEROSIS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>sev. mos.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>OCT 1</i> , 1957, to <i>OCT 31</i> , 1957, that I last saw the deceased alive on <i>10-30-57</i> , 19, and that death occurred at <i>23:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. Ellsworth Cook</i> M.D.		ADDRESS (Street, city or town, state) <i>2431 Maryland Avenue</i> DATE SIGNED <i>10/31/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. E. Ellsworth Cook</i>		<i>Baltimore, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/4/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>NOV 4 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Michael Gray</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 2

NOV 4 1957

RECEIVED

10393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 9mth12days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville, Md. 1615.2				d. STREET ADDRESS 5821 - 32nd Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle Litchfield Last Nutter				4. DATE OF DEATH Month October Day 25 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George W. Chase				14. MOTHER'S MAIDEN NAME Mary Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service) NONE				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized and severe							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 13 , 19 57 to Oct. 25 , 19 57 , that I last saw the deceased alive on Oct. 25 , 19 57 , and that death occurred at 3:25p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-25-57							
ACTUAL SIGNATURE Bruno Radauskas				PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/28/57		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cem	
22d. LOCATION (City, town, or county) (State) Columbia Maryland 21046, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 6 Riverside		24a. REC'D BY REGISTRAR DATE OCT 30 '57	
24b. REGISTRAR'S SIGNATURE W. W. Chambers							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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DATE OF DEATH

BUREAU V. B.

OCT 30 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10394

CERTIFICATE OF DEATH

10385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3404 Woodlawn Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle W. Last Percell		4. DATE OF DEATH Month 10 Day 7 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown THOMAS CONNOR		14. MOTHER'S MAIDEN NAME unknown TERESA CONROY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-14-1091	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized and severe		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 21 , 19 57 , to Oct. 7 , 19 57 , that I last saw the deceased alive on Oct. 7 , 19 57 , and that death occurred at 12:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-7-57			
ACTUAL SIGNATURE Stella Wachslar M.D.			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/10/57	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemt.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Elvener Hoffmann		24. REGISTRAR'S SIGNATURE Alfred Leach	
ADDRESS 3218 Hudson St.		DATE Oct 10 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

62-5386

BUREAU V. M.

1957 OCT 10

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10386

10395

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr7mth3dys					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City, Maryland					
f. STREET ADDRESS 34 Park Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Mead Last Poisal				4. DATE OF DEATH Month October Day 17 Year 1957					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown 1/4/83			
9. AGE (In years last birthday) 74 73? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic					
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME unknown 2nd J Meade				14. MOTHER'S MAIDEN NAME unknown Mary Ellen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. unknown					
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Balt-				20g. (County) Md		20h. (State) Md			
21. I certify that I attended the deceased from Sept. 11 , 19 57 , to Oct. 17 , 19 57 , that I last saw the deceased alive on Oct. 17 , 19 57 , and that death occurred at 3:55a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-17-57 ACTUAL SIGNATURE Spella Wachsler M.D. PHYSICIAN'S NAME (Type) Spella Wachsler, M. D. Catonsville 28, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-1957		22c. NAME OF CEMETERY OR CREMATORY Landon Park		22d. LOCATION (City, town, or county) (State) Balt- Md			
23. FUNERAL DIRECTOR'S SIGNATURE Mac Nabbs Son				ADDRESS 28		24a. RECEIVED BY REGISTRAR DATE Oct 23 1957			
24b. REGISTRAR'S SIGNATURE W. Leach									

RECEIVED

OCT 23 1957

BUREAU V. 3

CERTIFICATE OF DEATH

MAX LAND STATE DEPARTMENT OF HEALTH - BATHING, 12

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10387

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Bishop Lane</u>				d. STREET ADDRESS <u>103 Bishop Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John F. Porter</u>				4. DATE OF DEATH Month Day Year <u>Oct. 6 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 26 1991</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas & Elec. Co</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S .A</u>	
13. FATHER'S NAME <u>Andrew J. Porter</u>				14. MOTHER'S MAIDEN NAME <u>Clara C. Priester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W. W. 1</u>		17. INFORMANT <u>Eva M. Porter</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto U.S. National</u>	
22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>							
23. FLUNERAL DIRECTOR'S SIGNATURE <u>Mac Duff & Son</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Rebeach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 9 1957
BUREAU V. 8

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD.		b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 4 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 DUNDALK 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 BROADSHIP Rd				d. STREET ADDRESS 1 28 BROADSHIP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE E FRANKLIN RAIVEL				4. DATE OF DEATH Month Day Year 10-15-1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 JULY 1884		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY SANITATION MUNICIPAL GOVT.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEO. E. RAIVEL				14. MOTHER'S MAIDEN NAME JNK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (?)		17. INFORMANT Address IDA WALTER RAIVEL - SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary Thrombosis DUE TO (b) Arterio-sclerosis heart disease DUE TO (c) Diabetes mellitus Interval between onset and death: 2 days / 10 years / ? CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-8, 1957 to 10-15, 1957, that I last saw the deceased alive on 10-15, 1957, and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eugene F. Nery M.D. 7001 Mornington Rd Dundalk 22, Md							
ACTUAL SIGNATURE Eugene F. Nery		PHYSICIAN'S NAME (Type) Eugene F. Nery M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		10/15/57		GARDENS OF FAITH		BALTO. CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Burke Buckley, Dundalk, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE DATE OCT 17 1957 Jm. Kelly	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

BUREAU V. 3

OCT 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

CERTIFICATE OF DEATH

10389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>Since 1938</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Dr. School</u>				d. STREET ADDRESS <u>Cumberland 0102.2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Albert Raupach</u>				4. DATE OF DEATH Month Day Year <u>October 12 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-24</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pt. in Inst.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Albert Milton Raupach</u>				14. MOTHER'S MAIDEN NAME <u>Leah Leydig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records</u>		Address <u>Rosewood Owings Mills, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonitis</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 11</u> , 19 <u>57</u> , to <u>Oct 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 12</u> , 19 <u>57</u> , and that death occurred at <u>3:10 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rosewood Owings Mills, Md</u> DATE SIGNED <u>10/12/57</u>							
ACTUAL SIGNATURE <u>Violet B. Johns</u>				M.D. <u>Rosewood Owings Mills, Md</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>St. Johns Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Steen Francis Home</u>				ADDRESS <u>Cumberland</u>		24a. REC'D BY REGISTRAR DATE <u>14 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
PLACE OF BIRTH _____		OCCUPATION _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

BURKAY & S

OCT 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10390	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 37	
Items 8,9: G222 10-28-57 L											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY A. A. Co.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgewood				c. LENGTH OF STAY IN 1b 4 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hghts 02X2.2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4102 West Drive					d. STREET ADDRESS 147 Nursery Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roland Middle Reigle Last			4. DATE OF DEATH Month OCT. 21 Day 1957 Year 19								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1899 Sept. 7, 1899		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wire Man				10b. KIND OF BUSINESS OR INDUSTRY Western Elec.		11. BIRTHPLACE (State or foreign country) Odenton, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William T. Reigle					14. MOTHER'S MAIDEN NAME Cora C. Simpson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. -- 216-10-8926			17. INFORMANT Mrs. Pauline Reigle			Address Same As #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 Coronary Thrombosis DUE TO (c) 420.1 Coronary Thrombosis DUE TO (c) 420.1 Coronary Thrombosis										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED Oct. 21, 1957			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Oct. 25/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.			22d. LOCATION (City, town, or county) Baltimore, Md.			(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Singleton					ADDRESS Glen Burnie, Md.			24a. REC'D BY REGISTRAR OCT 24 57		24b. REGISTRAR'S SIGNATURE W. J. Leach	

BUREAU V. S.

OCT 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10399

CERTIFICATE OF DEATH

10391

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle E. Last REVELY				4. DATE OF DEATH Month October Day 19 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/07	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James E. Revely				14. MOTHER'S MAIDEN NAME Amanda Flashman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service Yes WWII				16. SOCIAL SECURITY NO. 218-03-3780		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PONTINE (BRAIN STEM) HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) VASCULAR NEPHRITIS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 11, 1957 , to October 19, 1957 , and that death occurred at 4:55 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Donald D. Mark M.D. Veterans Administration Hospital 10/20/57							
ACTUAL SIGNATURE Donald D. Mark							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M. D. Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802 Madison Avenue		24a. REC'D BY REGISTRAR DATE 01-23-57	
				24b. REGISTRAR'S SIGNATURE Dawson J. Farley			

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1895		BALTIMORE, MARYLAND	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JUN 15 1915		BALTIMORE, MARYLAND	
EDUCATION		SCHOOL		CITY	
HIGH SCHOOL		BALTIMORE		BALTIMORE	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
LABORER		OCT 15 1957		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
HEART DISEASE		NATURAL		100-10000	
DISEASE		DATE OF INTERMENT		PLACE OF INTERMENT	
PNEUMONIA		OCT 20 1957		BALTIMORE, MARYLAND	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
OCT 20 1957		BALTIMORE		BALTIMORE	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
OCT 20 1957		BALTIMORE		BALTIMORE	

BUREAU V. S.

OCT 25 1957

RECEIVED

10400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol. 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Masonic Home</u>				d. STREET ADDRESS <u>112 E 20th St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>L</u> Last <u>Reynolds</u>				4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-1878</u> 29 yrs.	
9. AGE (In years last birthday) <u>79</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Gustav Solder</u>			
14. MOTHER'S MAIDEN NAME <u>Susette Bittel</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Kathryn S. Thompson, R.N.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arterio Sclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u>				20g. (County) <u>md.</u>		20h. (State) <u>md.</u>	
21. I certify that I attended the deceased from <u>10-8</u> , 1956, to <u>Oct. 30</u> , 1957, that I last saw the deceased alive on <u>Oct. 28</u> , 1957, and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. <u>Walter J. Kues</u> ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Walter J. Kues</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lowden</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc</u>				ADDRESS <u>1217 St Paul St</u>		24a. REC'D BY REGISTRAR DATE NOV 4 '57	
24b. REGISTRAR'S SIGNATURE <u>Overman</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 15, 1912*

5. PLACE OF BIRTH: *Baltimore, Md.*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *Nov 10, 1957*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF PHYSICIAN: *[Signature]*

11. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. S.

NOV 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10401 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10393

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyde</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyde</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>G.</u> Last <u>Riddle</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1895</u>		
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Schools</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Grote</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Weigand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>J. Frank Riddle, Hyde, Maryland</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>		DATE SIGNED <u>10-8-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>md</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Pikesville, Maryland</u>		(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>Oct 10 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Qu. Leach</u>		DATE <u> </u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>	
DATE OF DEATH <i>Jan 15, 1925</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		MEDICAL HISTORY <i>None</i>	
SIGNATURE OF EXAMINER <i>J. H. Smith</i>		DATE <i>Jan 15, 1925</i>		PLACE <i>Baltimore</i>	
FAMILY HISTORY <i>None</i>		SOCIAL HISTORY <i>None</i>		OCCUPATION <i>None</i>	
EDUCATION <i>None</i>		RELIGION <i>None</i>		MARRIAGE HISTORY <i>None</i>	
CHILDREN <i>None</i>		SIBLINGS <i>None</i>		PARENTS <i>None</i>	
GRANDPARENTS <i>None</i>		AUNT/UNCLES <i>None</i>		COUSINS <i>None</i>	
BROTHERS <i>None</i>		SISTERS <i>None</i>		OTHER RELATIVES <i>None</i>	
FRIENDS <i>None</i>		ACQUAINTANCES <i>None</i>		OTHER PERSONS <i>None</i>	
TOTAL <i>None</i>		TOTAL <i>None</i>		TOTAL <i>None</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10394

33

10402

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Rosewood State Training School o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3V01-4			
f. STREET ADDRESS 907 W. Saratoga Street, Apt. 4				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michael Middle Steven Last Riggs				4. DATE OF DEATH Month 10 Day 24 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/23/54	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Riggs				14. MOTHER'S MAIDEN NAME Myrtle L. McCullers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Rosewood records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia DUE TO (c) Convulsions							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Necrosis of cerebral cortex due to former infection & shock							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/16 19 57 , to 10/24/19 57 that I last saw the deceased alive on 10/24/ 19 57 , and that death occurred at 10:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/25/57							
ACTUAL SIGNATURE Rich. Lindenberg M.D.							
PHYSICIAN'S NAME (Type) Rich. Lindenberg							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10/26/57		22c. NAME OF CEMETERY OR CREMATORY Arbutus Cem		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Wilson ADDRESS 1000 Baiting Ave				24a. REC'D BY REGISTRAR DATE 10/29/57		24b. REGISTRAR'S SIGNATURE Mary E. King	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

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OCT 30 1957

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10271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) on STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe, Md.</u>		c. LENGTH OF STAY IN 1b <u>.51</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>MICHAEL</u> Middle <u>RODAN</u> Last		4. DATE OF DEATH <u>Oct. 24</u> Month <u>24</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 29 - 1899</u> yrs. <u>38</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prester</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy Rodan</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Dosselly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>10/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>57</u> , and that death occurred at <u>6:12</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Halethorpe, Md.</u> DATE SIGNED <u>10/16/57</u>			
ACTUAL SIGNATURE <u>John C. Healy</u> M.D.		PHYSICIAN'S NAME (Type) <u>Halethorpe, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Oct 28 - 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Catharine</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick R. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gertrude Perry</u> ADDRESS <u>1246 Carroll</u>		24a. REC'D BY REGISTRAR <u>OCT 30 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Kiffey</u>

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OCT 30 1957

1957 OCT 30

BUREAU A

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10396

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>53</u> <u>Dundalk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>76 Kinship Road</u>		d. STREET ADDRESS <u>76 Kinship Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACK Red ROBERTSON</u>		4. DATE OF DEATH Month Day Year <u>October 15 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Hot Springs, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph W. Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Florence E. Rowan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>265-09-9870</u>	
17. INFORMANT Address <u>Mrs. Virginia Carmen 5104 Crest Ave. Cheverly, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Paul F. Guerin</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Paul F. Guerin, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 16, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlane Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Millboro, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ullrich Funeral Home 4210 Belair Road.</u>		24a. REC'D BY REGISTRAR DATE <u>10/21/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>			

RECEIVED

OCT 22 1957

BUREAU W. A.

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103978

. 10403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 FAIRMOUNT AVE</u>		d. STREET ADDRESS <u>412 FAIRMOUNT AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES H. ROBINSON</u>		4. DATE OF DEATH Month Day Year <u>10 14 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STABLE OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ZELMA GARDNER-412 FAIRMOUNT AVE.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X Intestinal Hemorrhage (Rupture)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Stomach</u> DUE TO (c) <u>Inoperable Carcinomatous growth in Transverse Colon and Stomach.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease.</u> INTERVAL BETWEEN ONSET AND DEATH <u>one month.</u> <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Oct 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 13</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1532 E Monument St. Balto (5) Md 10/14/57</u>			
ACTUAL SIGNATURE <u>Ralph J. Young</u>		PHYSICIAN'S NAME (Type) <u>DR. J. CHATMAN JR. 1701 Mc Cullough St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO, MD</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 16 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10404

CERTIFICATE OF DEATH

10398

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 Washington Avenue				d. STREET ADDRESS 214 Washington Avenue			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETTA Middle JOHNSON Last ROGERS				4. DATE OF DEATH Month October Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1871	9. AGE (In years lost birthday) yrs. 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James T. John son				14. MOTHER'S MAIDEN NAME Mary S. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 14 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 57 , to Oct 23 , 19 57 , that I last saw the deceased alive on Oct 23 , 19 57 , and that death occurred at 11:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville, Md DATE SIGNED 10/25/57 ACTUAL SIGNATURE George T. Gilmore M.D. Lutherville, Md PHYSICIAN'S NAME (Type) GEORGE T. GILMORE MD LUTHERVILLE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery		22d. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Soro ADDRESS Towson, Maryland				24a. REC'D BY REGISTRAR Oct. 25, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE

DATE OF DEATH

PLACE OF DEATH

HOSPITAL

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

HOSPITAL

CAUSE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

HOSPITAL

CAUSE OF DEATH

BUREAU V. 3

OCT 28 1957

RECEIVED

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10399

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN 1b 55	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 214 Washington Avenue		d. STREET ADDRESS 214 Washington Avenue	
3. NAME OF DECEASED (Type or print) HARRY K. ROGERS		4. DATE OF DEATH October 19 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Bank Building	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William G. Rogers	
14. MOTHER'S MAIDEN NAME Elizabeth Rogers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-14-3610A		17. INFORMANT Family records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse 561.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Due To Strangulated Hernia (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 Days			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery	22d. LOCATION (City, town, or county) (State) Cockeysville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Lono		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR OCT 23 1957		24b. REGISTRAR'S SIGNATURE Hubert Grays	

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

FOR YEAR
1957

BUREAU V. S.

OCT 28 1957

RECEIVED

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status		Social Status		Other Information	
JAMES H. JONES		Male		35		1922		Maryland		1957		Maryland		Heart Disease		Natural		Farmer		High School		Roman Catholic		Married		Middle Class		None	
Date of Death		Place of Death		Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status		Social Status		Other Information		Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
1957		Maryland		Heart Disease		Natural		Farmer		High School		Roman Catholic		Married		Middle Class		None		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 21 1957

RECEIVED

CERTIFICATE OF DEATH

10401/

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore d. STREET ADDRESS 2814 Presstman St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN I SAUNDERS		4. DATE OF DEATH Month October Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1919
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Windsor, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Saunders		14. MOTHER'S MAIDEN NAME Mattie Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 228-14-7467	
17. INFORMANT Clin Rec. Vet Adm Hosp. Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN ABSCESS RIGHT CEREBRAL HEMISPHERE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 25 , 19 57 , to Oct. 27 , 19 57 , and that death occurred at 3:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Fort Howard, Maryland 10/27/57			
ACTUAL SIGNATURE T. Lawrence Fleisher M.D. Fort Howard, Maryland			
PHYSICIAN'S NAME (Type) T. LAWRENCE FLEISHER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10/27/57	22c. NAME OF CEMETERY OR CREMATORY Chapel Grove Christian	22d. LOCATION (City, town, or county) (State) Windsor, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE William C. March		24a. REC'D BY REGISTRAR 28 1957	
ADDRESS 925 E. North Ave.		24b. REGISTRAR'S SIGNATURE Lawson L. Sherry	
William C. March, 2305 Dukeland St., Baltimore, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		John J. H. H.	
Sex		Male	
Age		28	
Date of Birth		June 23, 1919	
Place of Birth		Indian, Virginia	
Usual Residence		Little Rock, Arkansas	
Cause of Death		22-10-21; Clin. Adm. Hosp. St. Howard, Md.	
Date of Death		October 22, 1957	
Place of Death		St. Howard Hospital	
Signature of Physician		J. H. H.	
Signature of Registrar		J. H. H.	

BUREAU V. A.

OCT 28 1957

RECEIVED

Special Agent in Charge, Indian, Virginia

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the coroner prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10403

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pulaski Highway</u>				d. STREET ADDRESS <u>Red Lion Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sayler</u> Middle <u>Merle</u> Last <u>Richard</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1907</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Arsenal</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Sayler</u>				14. MOTHER'S MAIDEN NAME <u>Florence Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-4398</u>		17. INFORMANT Address <u>Mrs. Ellen M. Sayler Red Lion Rd. White Marsh</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) Compound fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2) Compound fracture rt. foreleg</u> DUE TO (c) <u>3) Separation left foreleg</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>deceased was struck by oncoming vehicle while crossing street</u>					
20c. TIME OF INJURY Month, Day, Year <u>19 Oct. 57</u> Hour <u>10:10</u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pulaski Hgwy</u>		20f. (City or town) (County) (State) <u>White Marsh, Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W.E. Baermann</u>				DATE SIGNED <u>19 Oct. 1957</u>			
EXAMINER'S NAME (Type) <u>W.E. Baermann, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>REG 22 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Pennington</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 22 1987

RECEIVED

10407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6mths10dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Maryland 55			
d. STREET ADDRESS 504 Baltimore Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Allie Last Saylor				4. DATE OF DEATH Month October Day 2 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Robertsen				14. MOTHER'S MAIDEN NAME Charlotte White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 2 , 19 57 , to Oct. 2 , 19 57 , that I last saw the deceased alive on October 2 , 19 57 , and that death occurred at 3:00p.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-2-57 ACTUAL SIGNATURE Stella Wachslar M.D. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		22d. LOCATION (City, town, or county) (State) Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons				ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR DATE OCT 7 '57	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1872		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		OCT 5 1937		BALTIMORE, MD.	
FATHER		MOTHER		BORN		DIED		BURIED		INTERMENT	
JAMES H. HARRIS		MARY H. HARRIS		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	
DATE OF INTERVIEW		BY		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF WITNESSES	
OCT 7 1937		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

OCT 7 1937

RECEIVED

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1957

Form 100-1

BUREAU V. S.

NOV 5 1957

RECEIVED

10410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 12 FilmG221 10-18-57 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Baltimore 29	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn L. Martin, Co.		d. STREET ADDRESS 1027 Elmridge Ave.	
3. NAME OF DECEASED (Type or print) LEOPOLD SCHNEIDER		4. DATE OF DEATH Month 10 / Day 10 / Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/1901
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg.	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franz Schneider		14. MOTHER'S MAIDEN NAME Maria Makula	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-1238	
17. INFORMANT Dorothy O. Schneider		Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (a), stating the underlying cause last. DUE TO (c) YEARS		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.E. Baermann		DATE SIGNED	
EXAMINER'S NAME (Type) W.E. BAERMANN, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/14/57	
22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEM.		22d. LOCATION (City, town, or county) (State) DORSEY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE HOWARD H. HUBBARD--		ADDRESS 4107 WILKINS AV. (29)	
24a. REC'D BY REGISTRAR 14 1957		24b. REGISTRAR'S SIGNATURE Edith H. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5025

101-10-25

— 200 —

BUREAU V. 3.

OCT 14 1957

RECEIVED

Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10411

CERTIFICATE OF DEATH

10406

Reg. Dist. No. 36

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 711 Stoneleigh Rd.		d. STREET ADDRESS 711 Stoneleigh Rd.	
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last SEIDEL		4. DATE OF DEATH Month Oct. Day 30 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1894
9. AGE (In years lost birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Supt. Department Education	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Years	
13. FATHER'S NAME Henry J. Seidel		14. MOTHER'S MAIDEN NAME Barbara Zink	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World No. I none	
17. INFORMANT Mrs. Johanna Seidel - 711 Stoneleigh Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, acute. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular disease. DUE TO (c) Generalized arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH Sudden Years 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/28/1939 , 19____, to 10/30/57 , 19____, that I last saw the deceased alive on 10/29/57 , 19____, and that death occurred at 11:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 East Chase St., City-2. DATE SIGNED Edwin B. Jarrett ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Edwin B. Jarrett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/57	
22c. NAME OF CEMETERY OR CREMATORY Immanuel Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md.		24. REC'D BY REGISTRAR NOV 1 1957 24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 15 1905		BALTIMORE, MD.		JANE HARRIS		JUN 15 1905		BALTIMORE, MD.	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
LABORER		JUN 15 1905		BALTIMORE, MD.		HEART DISEASE		NATURAL		DR. J. H. HARRIS	
EDUCATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
HIGH SCHOOL		JUN 15 1905		BALTIMORE, MD.		HEART DISEASE		NATURAL		DR. J. H. HARRIS	
RELIGION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
METHODIST		JUN 15 1905		BALTIMORE, MD.		HEART DISEASE		NATURAL		DR. J. H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT		SIGNATURE OF REGISTRAR	
JUN 15 1905		BALTIMORE, MD.		HEART DISEASE		NATURAL		DR. J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10273

42

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus 51</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4721 Gateway Ter.</u>		d. STREET ADDRESS <u>4721 Gateway Ter.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES M.</u> Middle <u>SEYBOLD</u> Last <u>SEYBOLD</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/08</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James E. Seybold</u>		14. MOTHER'S MAIDEN NAME <u>W. Zell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mildred Seybold</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> cause last. <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo M. Kieffer</u>		DATE SIGNED <u>Oct. 3 57</u>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>Balt Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macdonald & Son</u>		24a. REC'D BY REGISTRAR <u>28</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Geo S. M. Kieffer</u>		DATE <u>Oct 4 1957</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

OCT 4 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 39 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First EDWARD Middle J. Last SHANNON		4. DATE OF DEATH Month October Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/97
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing shops	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas Shannon		14. MOTHER'S MAIDEN NAME Elizabeth Pannell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 218-01-4897	
17. INFORMANT Clin. Recs. Vets. Admin. Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 581.0 (1) CIRRHOSIS OF LIVER WITH ASCITES (2) PERINEPHRITIC ABSCESS RIGHT (3) CHRONIC AND ACUTE PYELONEPHRITIS WITH ABSCESSES BILATERAL (4) CHRONIC CYSTITIS WITH URINARY BLADDER STONE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 3, 1957 , to October 12, 1957 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 10/12/57			
ACTUAL SIGNATURE Chien Wei Lan M.D. Veterans Administration Hospital			
PHYSICIAN'S NAME (Type) CHIENT WEI LAN, M. D. Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 15, 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. Moran		24a. REC'D BY REGISTRAR DATE 14 1957	24b. REGISTRAR'S SIGNATURE Shawson & Farley

John Moran Funeral Home, Baltimore & Potomac Sts, Baltel, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Howard		Male		35 years	
Date of Death		Place of Death		Cause of Death	
October 12, 1957		John Howard Hospital		Myocardial Infarction	
Residence		Occupation		Manner of Death	
30 E. York Street		Salesman		Natural	
City		County		State	
Baltimore		Baltimore		Maryland	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date		Time		Place	
October 12, 1957		10:15 AM		John Howard Hospital	

(1) DISSECTION OF LIVER WITH ACUTE
(2) PERICARDIUM ACUTE NON-SPECIFIC
(3) CHRONIC AND ACUTE PERICARDITIS WITH FIBROSIS
(4) CHRONIC CYSTITIS WITH URINARY STASIS
(5) STASIS

BUREAU V. 3

OCT 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10410

10413

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>		d. STREET ADDRESS <u>126 STEAMERS</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE L SHAW</u>		4. DATE OF DEATH Month Day Year <u>10 24 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RIBERT HALL</u>		14. MOTHER'S MAIDEN NAME <u>MARY L. GRIFFITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>PT'S Record</u>	
17. INFORMANT Address <u>PT'S Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>year</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 15, 1957</u> to <u>Oct 24, 1957</u> that I last saw the deceased alive on <u>Oct 24, 1957</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 10-25-57</u>	
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>		<u>Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 28 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. W. L. Lamoreau</u> ADDRESS <u>4510 Liberty Heights Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '57</u> 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

BUREAU V. S.

OCT 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

104111

104114

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN IB 27 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Baltimore DUNDALK (22)	
d. STREET ADDRESS 2946 Yorkway		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last SHEETS		4. DATE OF DEATH Month October Day 8 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 8 Days 8 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - Retired		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill	
11. BIRTHPLACE (State or foreign country) Nightly Hall, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Sheets		14. MOTHER'S MAIDEN NAME Martha Keatley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) P. I.		16. SOCIAL SECURITY NO. 213-07-9218	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POST OPERATIVE (TUR) HEMORRHAGE AND SHOCK DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) FIBRINOLYTIC ENZYMIC ACTIVITY DUE TO CARCINOMA PROSTATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS UNKNOWN.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Transurethral Resection 10/8/1957		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 10 Day 8 Year 1957 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 11, 1957 , to October 8, 1957 and that death occurred at 1:25 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/8/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks-Bradley, Inc. ADDRESS 700 Willow Springs Road Baltimore, Maryland		24b. REGISTRAR'S SIGNATURE E. D. L. Farber	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature.

BUREAU V. 2

OCT 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10415

CERTIFICATE OF DEATH

10412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth9dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4	
3. NAME OF DECEASED (Type or print) First William Middle Sirrenberg Last Sirrenberg		4. DATE OF DEATH Month October Day 13 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman		10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp.	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-4712	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 5 , 19 57 , to October 13 , 19 57 ; that I last saw the deceased alive on Oct. 13 , 19 57 , and that death occurred at 7:30a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Isadore Tuerk		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-14-57	
PHYSICIAN'S NAME (Type) Isadore Tuerk, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10-15-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) C.A. Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE Isadore Tuerk ADDRESS 5305 Harford Rd.		24a. REC'D BY REGISTRAR DATE Oct 16 57 24b. REGISTRAR'S SIGNATURE W. H. Smith	

RECEIVED
OCT 16 1957
BUREAU V. S.

OCT 16 1957

10416

CERTIFICATE OF DEATH

10413

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 18yrl4mthldy			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspeburg, Maryland				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			
d. STREET ADDRESS 414 Babikow Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle May Last Smith				4. DATE OF DEATH Month October Day 20 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1884	
9. AGE (In years last birthday) 73 7/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jacob Allison				14. MOTHER'S MAIDEN NAME Anna Bohn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of left breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 25 , 19 57 , to Oct. 20 , 19 57 , that I last saw the deceased alive on Oct. 20 , 19 57 , and that death occurred at 2:00p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 10-21-57							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist		22d. LOCATION (City, town, or county) (State) Freeland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ward				ADDRESS 1401 Balas		24a. REC'D BY REGISTRAR DATE OCT 23 57	
				24b. REGISTRAR'S SIGNATURE Deborah			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10417

Item 4 File 0221 10-20-57 et

CERTIFICATE OF DEATH

10414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>710 Linda Drive</u>		d. STREET ADDRESS <u>47 Della Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Gloria</u> First <u>Smith</u> Middle <u>Ann</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>19 57</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JESSE PORTER</u>		14. MOTHER'S MARDEN NAME <u>ELANOR REEVES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-14-9408</u>	
17. INFORMANT <u>Roy Smith</u>		Address <u>47 DELLA AVE. DELLA, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE.</u> <u>331 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>ARTERIOSCLEROSIS.....</u> DUE TO (c) <u>5-10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>57</u> , to <u>OCT '19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>OCT. 18</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6348 FREDERICK ROAD. CATONSVILLE BAL-28</u> DATE SIGNED <u>10/21/57</u> ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D. PHYSICIAN'S NAME (Type) <u>S. LLOYD JOHNSON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Higginbotham</u>		ADDRESS <u>Ellicott City</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 23 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

OCT-23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 ~~2~~
Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,8,9 Film G222 11-14-57 et

10418
CERTIFICATE OF DEATH

10415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 23yr9mth12 dy					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2230 Wilkens Avenue					
3. NAME OF DECEASED (Type or print) CHARLES LOON First Middle				4. DATE OF DEATH OCT. 26, 1957 Month Day Year					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1886			
9. AGE (In years last birthday) 71-76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Charles Sommers				14. MOTHER'S MAIDEN NAME Sarah Mary KANE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction + Uremia DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Prostate DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Oct. 18, 1957 , to Oct. 26, 1957 , that I last saw the deceased alive on Oct. 26, 1957 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE C. Eugene Watermann M.D.				SPRING GROVE STATE HOSPITAL					
PHYSICIAN'S NAME (Type) C. Eugene Watermann				Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
BURIAL		10-26-57		Leudon PARK		BALTIMORE Md.			
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schwalb				ADDRESS 2101 Frederick Ave		24a. REC'D BY REGISTRAR Oct 28 57			
						24b. REGISTRAR'S SIGNATURE Oct 28 57			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BATTLE ONE 10

RECEIVED
OCT 28 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10416

10419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annerville</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Webster</u> First <u>C.</u> Middle <u>Tall</u> Last				4. DATE OF DEATH Month <u>10</u> - Day <u>23</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 8, 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer (rtd.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Grant Tall</u>		14. MOTHER'S MAIDEN NAME <u>Julia Teresa Bians</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Adele D. Tall - 1626 Bolton St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Vermis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Diabetic nephropathy</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asteris sclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 mos</u> <u>9 yrs -</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>57</u> , to <u>Oct 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>57</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest C. Brown</u> M.D.				ADDRESS (Street, city or town, state) <u>1101 N. Calvert St</u>		DATE SIGNED <u>10/23/57</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickner & Sons - Balto, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DET 28 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 62-100

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10417

10420

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md. c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 340114	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 1802 W. NORTH AVENUE	
3. NAME OF DECEASED (Type or print) First WALTER Middle BROWN Last TAYLOR		4. DATE OF DEATH Month OCTOBER Day 8 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET CAR OPERATOR		12. 10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE TRANSIT	
13. FATHER'S NAME SAMUEL T. TAYLOR		14. MOTHER'S MAIDEN NAME MARY BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO		16. SOCIAL SECURITY NO. 213-10-1548	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CO2X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNCERTAIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1957 , to Oct 8, 1957 , that I last saw the deceased alive on Oct 8, 1957 , and that death occurred at 9 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.			
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers ADDRESS Home Randallstown		24a. REC'D BY REGISTRAR Dorothy Jewell DATE 10/14/57	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND

DATE OF DEATH: _____

PLACE OF DEATH: _____

AGE: _____

SEX: _____

RACE: _____

EDUCATION: _____

OCCUPATION: _____

CAUSE OF DEATH: _____

IMMEDIATE CAUSE: _____

UNDERLYING CAUSE: _____

PERIODICITY: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

AGE: _____

SEX: _____

RACE: _____

EDUCATION: _____

OCCUPATION: _____

CAUSE OF DEATH: _____

IMMEDIATE CAUSE: _____

UNDERLYING CAUSE: _____

PERIODICITY: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

BUREAU V. 8

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10421

CERTIFICATE OF DEATH

10418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas		c. LENGTH OF STAY IN 1b x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS EGAN THOMPSON		4. DATE OF DEATH Month Day Year October 1, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1874
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quarryman- retired		10b. KIND OF BUSINESS OR INDUSTRY Stone Quarry	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Thompson		14. MOTHER'S MAIDEN NAME Mary Ann Knopp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/17 , 19 57 , to 10/1 , 19 57 , that I last saw the deceased alive on 10/1 , 19 57 , and that death occurred at 12:40 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville DATE SIGNED 10/4/57 ACTUAL SIGNATURE Bennett A. Stoen M.D. Lutherville PHYSICIAN'S NAME (Type) Bennett A. Stoen Lutherville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 4, 1957	
22c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery		22d. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burner Somo		24a. REC'D BY REGISTRAR DATE 10/7/57	
ADDRESS Towson, Maryland		24b. REGISTRAR'S SIGNATURE Overman	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

File No.

John Doe

John Doe

Baltimore

John Doe

John Doe

John Doe

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BUREAU V. 3

OCT 7 1957

RECEIVED

10422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 11mth27dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 10 West Preston St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Ellwood Last Thomson				4. DATE OF DEATH Month October Day 7 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watch repairman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John J. Thomson				14. MOTHER'S MAIDEN NAME Mary J. Ohler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 202-03-5786		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET OF DEATH years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 12 , 19 57 , to Oct. 7 , 19 57 , that I last saw the deceased alive on Oct. 7, 1957 , and that death occurred at 11.15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-11-57 ACTUAL SIGNATURE Stella Wachsler M.D. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/57		22c. NAME OF CEMETERY OR CREMATORY Fleethwood		22d. LOCATION (City, town, or county) (State) Fleethwood, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Little Funeral Home Littleton Pa.				24a. REC'D BY REGISTRAR Oct 11 1957		24b. REGISTRAR'S SIGNATURE Oct 11 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG-100 (10-1-57)

1. NAME OF DECEASED JOHN J. ROY		2. SEX MALE	
3. AGE 45		4. RACE WHITE	
5. DATE OF BIRTH 1912		6. PLACE OF BIRTH NEW YORK	
7. DATE OF DEATH 1957		8. PLACE OF DEATH NEW YORK	
9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF REGISTRAR [Signature]	
13. SIGNATURE OF WITNESS [Signature]		14. SIGNATURE OF WITNESS [Signature]	
15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]	
23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]	
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31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]	
33. SIGNATURE OF WITNESS [Signature]		34. SIGNATURE OF WITNESS [Signature]	
35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]	
39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF WITNESS [Signature]	
41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]	
43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]	
45. SIGNATURE OF WITNESS [Signature]		46. SIGNATURE OF WITNESS [Signature]	
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71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]	
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81. SIGNATURE OF WITNESS [Signature]		82. SIGNATURE OF WITNESS [Signature]	
83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]	
87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF WITNESS [Signature]	
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91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]	
93. SIGNATURE OF WITNESS [Signature]		94. SIGNATURE OF WITNESS [Signature]	
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97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]	
99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	

BUREAU V. 3

OCT 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10423

CERTIFICATE OF DEATH

Reg. Dist. No.

1042031

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3804 Arbutus Ave				d. STREET ADDRESS 3804 Arbutus Ave 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Henry A. Tiedemann				4. DATE OF DEATH Month Day Year Oct. 20/57 19			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1913	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Fidelity & Deposit Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Tiedemann				14. MOTHER'S MAIDEN NAME Queen Armsworthy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Dorothy Tiedemann, 3804 Arbutus Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute posterior myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 90 min.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 20 , 19 57 , to Oct 20 , 19 57 , that I last saw the deceased alive on Oct 20 , 19 57 , and that death occurred at 7:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3600 Lochearn Dr. DATE SIGNED Oct 22/57 ACTUAL SIGNATURE Daniel Bakal M.D. PHYSICIAN'S NAME (Type) DANIEL BAKAL, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24/57		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.Pk.		22d. LOCATION (City, town, or county) (State) Dorsey, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Director, 4101 Edmondson Ave				24a. REC'D BY REGISTRAR 10/23/57 24b. REGISTRAR'S SIGNATURE Dr. Jm. E. Martin			

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 24 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10264

CERTIFICATE OF DEATH

10421 41
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
				d. STREET ADDRESS 1 Dunleer Apts.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MAUDE Middle MEADOW Last TYREE				4. DATE OF DEATH Month Oct. Day 24 , Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby Sitter		10b. KIND OF BUSINESS OR INDUSTRY Rose Hackett		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Archie Tyree, son, 2538 Ashland Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-24 , 19 57 to 10-24 , 19 57 , that I last saw the deceased alive on 10-24-57 , 19 57 , and that death occurred at 5:30 p. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE M.B. Davis				DATE SIGNED 6800 MORNINGTON RD			
PHYSICIAN'S NAME (Type) M. B. DAVIS M.D.				DUNDALK-22 MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/57		22c. NAME OF CEMETERY OR CREMATORY Hak Lawn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schlimmek Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE 28 1957		24b. REGISTRAR'S SIGNATURE Wm. Kelly	
2601 E. Madison St.							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1100 N. W. 10th St., Baltimore, Md.		Salesman		Myocardial Infarction		Natural		Baltimore, Md.	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
OCT 28 1967		10:15 AM		10		15		00	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
Baltimore, Md.		OCT 28 1967		10:15 AM		10		15	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
OCT 28 1967		10:15 AM		10		15		00	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
Baltimore, Md.		OCT 28 1967		10:15 AM		10		15	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
OCT 28 1967		10:15 AM		10		15		00	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
Baltimore, Md.		OCT 28 1967		10:15 AM		10		15	

BUREAU V. 3

OCT 28 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the religious rites prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10424

CERTIFICATE OF DEATH

1042244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle L. Last UPPERCO, SR.		4. DATE OF DEATH Month October Day 6 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/82
9. AGE (In years lost birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dickson Upperco		14. MOTHER'S MAIDEN NAME Anna Mitten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES 581.0 DUE TO CIRRHOSIS OF LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 14 DAYS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 22 1957 to October 6 , 19 57 , that he died on October 6 at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED CHIHEN WEI LAN, M.D. Veterans Administration Hospital 10/7/57			
22. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Oct. 10/1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE W. P. Wippert	
24a. REC'D BY REGISTRAR W. P. Wippert		24b. REGISTRAR'S SIGNATURE Newton L. Farley	

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BUREAU V. S.

1957 OCT 6

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10426

CERTIFICATE OF DEATH

1042344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 807 S. Bradock Street	
3. NAME OF DECEASED (Type or print) First LOUIS Middle F Last VAUGHT		4. DATE OF DEATH Month October Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/29
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY Army Air Force	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Jackson Vaught		14. MOTHER'S MAIDEN NAME Vernie E. Hardy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. PL-28 Korean 229-34-7528	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA, ORGANISM UNKNOWN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE SCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1953 , to October 21, 1957 , and that death occurred at 3:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 10/22/57 ACTUAL SIGNATURE Irving Freeman M.D. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF OCT. 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Lauren P. Jones - Winchester, VA		24a. REC'D BY REGISTRAR 30 1957	
ADDRESS Winchester, VA		24b. REGISTRAR'S SIGNATURE Newton L. Farber	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. 8

OCT 30 1957

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10425

CERTIFICATE OF DEATH

10424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulleton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto md</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fitch Lane</u>		d. STREET ADDRESS <u>1243 Cleveland St</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>7</u> Last <u>Lox Bred</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 20 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hauling</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Henry</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bruestermann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-059055</u>	
17. INFORMANT <u>Wm Scaball Fitch Lane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous, generalized</u> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma, site unknown</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/19/1957</u> to <u>10/12/1957</u> that I last saw the deceased alive on <u>10/10/1957</u> , and that death occurred at <u>12:04 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Marion Friedman</u> M.D.		<u>1737 E. North Avenue, Baltimore 13, Md</u>	
PHYSICIAN'S NAME (Type) <u>MARION FRIEDMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 14 57</u>	<u>Fondren Rd.</u>	<u>Balto md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Newman</u> ADDRESS <u>6067 Tayford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Chapman</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

14 OCT 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10427

CERTIFICATE OF DEATH

10425
Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Arms 3700 Tudor Avenue			
3. NAME OF DECEASED (Type or print) First Alice Middle Viola Last Ward				4. DATE OF DEATH Month October Day 17 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1869	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Wesley Miles				14. MOTHER'S MAIDEN NAME Eileen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 15 , 19 57 , to Oct. 17 , 19 57 , that I last saw the deceased alive on Oct. 17 , 19 57 , and that death occurred at 7:55a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 10-17-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Wesley Grove		22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgess Funeral Home				ADDRESS 3631 Falls Rd.		24a. REC'D BY REGISTRAR DATE OCT 21 57	
				24b. REGISTRAR'S SIGNATURE W. J. ...			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

OCT 21 1957

RECEIVED

10428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessupville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella Louise</u> <u>Garden</u>		4. DATE OF DEATH Month Day Year <u>October</u> <u>5</u> <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-16-1863</u>
9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Jes. Garden</u>		14. MOTHER'S MAIDEN NAME <u>Sophia D. Hervey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>	17. INFORMANT Name <u>W. H. Williams</u> Address <u>310 E. Pratt St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized + cerebral arteriosclerosis</u> DUE TO (c) <u>yes -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-14-55</u> , 19 <u>55</u> , to <u>10-11-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 14</u> , 19 <u>57</u> , and that death occurred at <u>11:06 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emory C Brown Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>1101 N. Calvert St, Baltimore</u> DATE SIGNED <u>Oct 16, 57</u>	
PHYSICIAN'S NAME (Type) <u>Emory C Brown Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 19, 57</u>	<u>Greenwood</u>	<u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Morris</u>		ADDRESS <u>108 W. North Ave</u>	24a. REC'D BY REGISTRAR DATE <u>OCT 17 57</u>
		24b. REGISTRAR'S SIGNATURE <u>W. H. Williams</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Oct 15 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	
22. SIGNATURE OF CLERK <i>John Doe</i>		23. SIGNATURE OF RECTOR <i>John Doe</i>		24. SIGNATURE OF MINISTER <i>John Doe</i>	
25. SIGNATURE OF CHURCH <i>John Doe</i>		26. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		27. SIGNATURE OF BURIAL PLACE <i>John Doe</i>	
28. SIGNATURE OF INTERMENT <i>John Doe</i>		29. SIGNATURE OF CREMATION <i>John Doe</i>		30. SIGNATURE OF OTHER <i>John Doe</i>	

BUREAU W. 5

OCT 17 1957

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10429
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 N. Rolling Rd.				d. STREET ADDRESS 10 N. Rolling Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle WARFIELD Last WARFIELD				4. DATE OF DEATH Month Oct. Day 14, Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1871	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (rtd)				10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Henry W. Warfield				14. MOTHER'S MAIDEN NAME Sarah Ellen Whalen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Miss Mary E. Cromwell - 10 N. Rolling Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431X MYOCARDITIS SUBACUTE. DUE TO SENILITY AND GENERAL DETERIORATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 weeks (c) 3 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0			
20c. TIME OF INJURY Hour a. m. p. m. 0 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 , 19____, to OCT, 14 , 19 57 , that I last saw the deceased alive on OCT, 13 , 19 57 , and that death occurred at 7: A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6348. FREDERICK ROAD. CATONSVILLE MARYLAND. DATE SIGNED							
ACTUAL SIGNATURE S. Lloyd Johnson M.D.				PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/57		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS, Balto. 17, Md.				24a. REC'D BY REGISTRAR B.P.B.		24b. REGISTRAR'S SIGNATURE OCT 17 57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. R.

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10430

CERTIFICATE OF DEATH

10428 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN IB 37 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4			
4. DATE OF DEATH First Middle Last JOHN T. WATERS				5. DATE OF DEATH Month Day Year October 12 1957			
3. NAME OF DECEASED (Type or print)		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13, 1892	
5. SEX Male		9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Elkridge, Md.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkridge, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Waters				14. MOTHER'S MAIDEN NAME Levina Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-09-6548		17. INFORMANT Address Clin Rec. Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 10 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIAL FIBRILLATION. CHRONIC BRAIN SYNDROME ASSOCIATED WITH ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from September 5, 1957 , to October 12, 1957 , and that death occurred at 9:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Winston Dudley M.D.				PHYSICIAN'S NAME (Type) WINSTON DUDLEY, M.D. VAH, Fort Howard, Md. 10/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, Funeral Home,				24a. REC'D BY REGISTRAR DATE 10/15/57		24b. REGISTRAR'S SIGNATURE Lawson L. Laney	

OCT 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10274

CERTIFICATE OF DEATH

Reg. Dist. No.

104229

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1328 Poplar Avenue				d. STREET ADDRESS 1328 Poplar Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Lester Middle E. Last Wheley, Sr		4. DATE OF DEATH		Month October Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1903		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comptroller		10b. KIND OF BUSINESS OR INDUSTRY Butler Bros.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Wheley				14. MOTHER'S MAIDEN NAME Amelia Manko			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-6613		17. INFORMANT Address Mrs. Charlotte E. Wheley, 1328 Poplar Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 18, 19 57 to Oct. 19, 19 57 that I last saw the deceased alive on Oct. 18, 19 57 , and that death occurred at 4 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5305 East Drive Baltimore - 27, Md. DATE SIGNED							
ACTUAL SIGNATURE Herbert J. Levickas M.D.				DATE SIGNED OCT 22 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-22-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street ADDRESS				24a. REC'D BY REGISTRAR DATE OCT 22 1957		24b. REGISTRAR'S SIGNATURE W. M. Kuffner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18

THE DEPT. OF HEALTH

RECEIVED
OCT 22 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10431

CERTIFICATE OF DEATH

10430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last WHITE		4. DATE OF DEATH Month October Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1922
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR: Months 34 Days 11 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oystering	
11. BIRTHPLACE (State or foreign country) Stevensville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry White		14. MOTHER'S MAIDEN NAME Dorothy R. Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216-18-2949	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOLE NEPHROSCLEROSIS 446X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) HEMORRHAGIC PANCREATITIS (c) MULTIPLE ABSCESES, KIDNEYS		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 3 DAYS 7 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 4, 1957 , to October 11, 1957 , and that death occurred at 4:58A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED CHIEH WEI LAN, M.D. 10/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 10/13/57			
22c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery			
22d. LOCATION (City, town, or county) (State) Stevensville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE James DeShields ADDRESS James DeShields Funeral Home, Easton, Maryland			
24a. REC'D BY REGISTRAR 16 1957			
24b. REGISTRAR'S SIGNATURE Newton L. Farley			

BUREAU V. S.

OCT 16 1955

RECEIVED

10275

CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1234 LINDEN AVE		d. STREET ADDRESS 1234 LINDEN AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT CLARENCE WIEGAND First Middle Last		4. DATE OF DEATH OCT. 4, 1957 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1890
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shoe Salesman		10b. KIND OF BUSINESS OR INDUSTRY Shoe Store	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles F. Wiegand		14. MOTHER'S MAIDEN NAME Dorethea Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-09-2049	
17. INFORMANT Clara F. Wiegand		Address 1234 Linden Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Carcinomatosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diagnosis established at operation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15 , 19 57 , to 10/4 , 19 57 , that I last saw the deceased alive on 10/4 , 19 57 , and that death occurred at 8:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Bealy M.D.		ADDRESS (Street, city or town, state) Baltimore, Md DATE SIGNED 10/5/57	
PHYSICIAN'S NAME (Type) John C. Bealy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-8-57	22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park	22d. LOCATION (City, town, or county) (State) Balto. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	
24a. REC'D BY REGISTRAR OCT 7 1957		24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Luff	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 2 1957

RECEIVED

Item 2 ByPhone ED 10-25-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 1043233

10432

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 8 mo., 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2823 Miles Ave. d. STREET ADDRESS NAS NR-1 Office, Patuxent River e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Ann Last Williams		4. DATE OF DEATH Month 10 Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/56
9. AGE (In years last birthday) 1 yr		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Donald Franklin Williams		14. MOTHER'S MAIDEN NAME Ellen May Lutwyche	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Rosewood records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Convulsive state - myoclonic type DUE TO (c) 2/13/57			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital cerebral defect of undetermined type with severe mental defect.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/13/ 19 57 , to 10/18/ 19 57 , that I last saw the deceased alive on 10/18/ 19 57 , and that death occurred at 8:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry G. Butler M.D.		ADDRESS (Street, city or town, state) Owings Mills Md DATE SIGNED 10/18/57	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Rosewood State Training School	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Balto National	22d. LOCATION (City, town, or county) (State) Cotonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Bowman ADDRESS 3818 Roland Ave		24a. REC'D BY REGISTRAR OCT 22 1957	24b. REGISTRAR'S SIGNATURE Mary Elmer

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BIRTH OR DEATH
CERTIFICATE OF DEATH

Usual residence on birth certificate: 900 Homestead Ct.
Balto. 18
By phone to City Health
10-25-57 ams

BUREAU V. S.

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10433

10433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hollow Road				x2 d. STREET ADDRESS Oella Hollow Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN NAOMI WILLINGHAM				4. DATE OF DEATH Month Oct. Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-26-1912	
9. AGE (In years last birthday) 45 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Oella, Md	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Arch Willingham				14. MOTHER'S MAIDEN NAME Mary Jane Kelbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-20-9711		17. INFORMANT Arch Willingham, Oella, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral & Aortic Valvular Disease DUE TO (c) Rheumatic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 344 hrs. 344 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 52 , to OCT 17 , 19 57 , that I last saw the deceased alive on OCT 17 , 19 57 , and that death occurred at 10:15 M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Cliff Ratliff Jr. M.D. 4605 EDMONDSON AVE				10/18/57			
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.				4605 EDMONDSON AVE.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C.Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR OCT 21 '57		24b. REGISTRAR'S SIGNATURE Rede...	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. 2

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10434

CERTIFICATE OF DEATH

Reg. Dist. No.

2. DATE OF DEATH 10/6/57

1. NAME OF DECEASED (Type or Print)

ELMER WINANS

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALT CTY, MD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

8125 Ridgely Oak Ave.

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE MARRIED WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

State Roads Comm.

13. FATHER'S NAME

ELMER N. WINANS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

186-16-4938

8. DATE OF BIRTH

March 3, 1906

9. AGE (In years last birthday)

51

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

ELLA DEGNAN

17. INFORMANT

ADDRESS

Mrs. Florence K. Winans 8125 Ridgely Oak Av.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute Coronary Occlusion 1-5 min

DUE TO

ANTECEDENT CAUSES

(B) Coronary Artery Sclerosis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/30 to 10/6, that (I) (we) last saw the deceased alive on 8/7, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

F. J. BORGES

23B. ADDRESS

UNIVERSITY HPTL

23C. DATE SIGNED

10/6/57

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 9, 1957

24C. NAME OF CEMETERY OR CREMATORY

Moreland Memorial Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

10/8/57

REGISTRAR'S SIGNATURE

Wahl Gray

25. FUNERAL DIRECTOR

Longhans Funeral Home 7401 Belair Rd.

ADDRESS

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information is carefully supplied. Physicians: please write the causes of death clearly and let HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10435

CERTIFICATE OF DEATH

Reg. Dist. No.

10435

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home		d. STREET ADDRESS 3500 Callaway Avenue	
3. NAME OF DECEASED (Type or print) First Martha Ellen Wolff Middle Last		4. DATE OF DEATH Month October Day 25 Year 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1872
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles W. Lewis		14. MOTHER'S MAIDEN NAME Grace ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frederick Vernon Wolff		Address 2720 Harford Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-27 , 19 57 , to 10-25 , 19 57 , that I last saw the deceased alive on 10-18 , 19 57 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry S. Gimbel		ADDRESS (Street, city or town, state) 4605 Munson Ave - Baltimore Md	
PHYSICIAN'S NAME (Type) HARRY S. GIMBEL		DATE SIGNED 10-28-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth P. Parnett		24a. REC'D BY REGISTRAR DATE OCT 31 '57	
ADDRESS 4600 Liberty Heights Ave		24b. REGISTRAR'S SIGNATURE W. J. Couch	

CERTIFICATE OF DEATH

RECEIVED
OCT 31 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10436**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Blv. Extended</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> d. STREET ADDRESS <u>2916 W. North Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WOMACK</u> Last <u>WOMACK</u> 4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>19 57</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 12 - 32</u> 9. AGE (In years last birthday) <u>25</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (State or foreign country) <u>Virginia; Halifax County</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Dewey Womack</u> 14. MOTHER'S MAIDEN NAME <u>Evelyn Womack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <u>Billie Mae Womack</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>TRENCH CAVED IN & CAUGHT HIM -</u> 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m. 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>EAST 13th ST - EXT</u> 20f. City or town (County) (State) <u>Middle River</u> <u>Baltimore</u> <u>Md</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE <u>MP Davis</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>MP DAVIS M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Zion Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>EIROY O. WILSON</u>		ADDRESS <u>1000 Brantley Avenue</u>		22d. LOCATION (City, town, or county) (State) <u>Halifax County</u> <u>Virginia</u>			
24a. REG'D BY REGISTRAR (Date) <u>OCT 21 1957</u> REGISTRAR'S SIGNATURE <u>Edith Hurley</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10-23 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 21 1937
BUREAU V. S.

CERTIFICATE OF DEATH

10437

Reg. Dist. No.

10437

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3mth16dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater, Maryland			
f. STREET ADDRESS Box 412 - Edgewater, Md.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Wyatt				4. DATE OF DEATH Month October Day 22 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1878	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David M. Prettyman				14. MOTHER'S MAIDEN NAME Charlotte Ann Hastings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1957 , to Oct. 22, 1957 , that I last saw the deceased alive on Oct. 22, 1957 , and that death occurred at 9:40a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-22-57			
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMAINS (Specify) BURIAL		22b. DATE THEREOF 10-26-57		22c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		22d. LOCATION (City, town, or county) (State) SALISBURY MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Ann M. Parsons				24a. REC'D BY REGISTRAR DATE 10/24/57		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 28 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10438

CERTIFICATE OF DEATH

10438
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrlmthl4dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Baltimore (28)		d. STREET ADDRESS 17 DeSallus Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Yerman Last Yerman		4. DATE OF DEATH Month October Day 22 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883?
9. AGE (In years last birthday) 74? yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Phillip Yerman		14. MOTHER'S MAIDEN NAME Hani?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15 , 19 57 to Oct. 22 , 19 57 , that I last saw the deceased alive on Oct. 22 , 19 57 , and that death occurred at 3:55a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-22-57	
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-57	
22c. NAME OF CEMETERY OR CREMATORY Beth Tfeloh		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc		24a. REC'D BY REGISTRAR OCT 24 '57	
ADDRESS 2100 Cantaw Place		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

OCT 24 1957

RECEIVED

BUREAU V. 2

10439

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home		d. STREET ADDRESS 2820 Clifton Avenue	
3. NAME OF DECEASED (Type or print) First Anna Middle F. Last Yost		4. DATE OF DEATH Month October Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec, 8, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Henry T. Yost, 1312 E. Belvedere Avenue, ZONE 12		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1957 , to 23 Oct 1957 , that I last saw the deceased alive on 16 Oct 1957 , and that death occurred at 530 A.M. from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE W. E. Mc Grath M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md	
PHYSICIAN'S NAME (Type) W. E. Mc Grath M.D.		DATE SIGNED 23 Oct 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-25-57	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc. 1217 St. Paul Street		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE OCT 25 57			

RECEIVED